Arizona Department of Health Services

Office of Program Support

Children's Rehabilitative Services

Operations and Pro cedures Manual

Effective Date: 7/1/07

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Table of Contents

Section **Page**

Table of Contents

Introduction

The Office of Program Support (OPS) is within the Arizona Department of Health Services and provides oversight, coordination and monitoring to the Children's Rehabilitative Services Contractors (CRS). This document is a reference guide describing the procedural requirements between the CRS Sites, the Arizona Department of Health Services, Office of Program Support, and the Arizona Health Care Cost Containment System (AHCCCS). The Operations and Procedures Manual is available on the ADHS website and is to be used as the first point of reference when procedural questions arise.

Individuals with questions should contact their assigned Representative between the hours of 8:00 A.M. to 5:00 P.M. Monday through Friday.

Definitions

Aged Pended Encounter	An encounter that has pended for more than 120 calendar days, after the initial processing date at AHCCCS, without resolution.
AHCCCS	Arizona Health Care Cost Containment System
AHCCCSA	Arizona Health Care Cost Containment System Administration
AHCCCSA Error	A pended encounter which AHCCCS acknowledges to be the result of its own and has been communicated to the CRS Site by way of an edit alert, email, phone conversation, typed letter, Workgroup communication or other forum.
Check Register	A detailed log of all checks written and paid to providers for services rendered by a CRS Site. The check register should include, but is not limited to, check number, date the check was written, check amount, and provider name and ID.
Children's Rehabilitative System (CRS)	The data system used by ADHS/CRS.
Contract Year	A period from July 1 of a calendar year through and including June 30 of the following year.
CRN	Claim Reference Number, used to track and review encounters in the PMMIS system at AHCCCS.
Days	A calendar day unless otherwise specified
CRS Error	A pended encounter which ADHS/CRS acknowledges to be the result of its own error and has been communicated to the CRS Site by way of an edit alert, email, phone conversation, typed letter, Workgroup communication or other forum.

Definitions

Deleted Encounter	A pended encounter that has been deleted from the PMMIS system at AHCCCS by request from a CRS Site because the encounter was sent to ADHS in error or should not have been sent to AHCCCS by ADHS.
Encounter	A record of a covered service rendered by a provider to a person enrolled with a capitated CRS Site on the date of service
Enrollment	The process by which a person is enrolled into the Contractor and DHS data system
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.
GSA	Geographic Service Area
ICN	Internal control number used in the CIS system
Override (of Encounter)	A process performed by a CRS Site to bypass a pend status on an AHCCCS encounter which will allow the encounter to adjudicate cleanly.
Pended Encounter	An encounter that was sent to AHCCCS from ADHS that did not cleanly adjudicate but resulted in an error, known as a ñpendò.
Provider	Provider refers to all providers under contract with a CRS Site or a CRS network that deliver services to CRS clients (any provider that the CRS Site will receive a claim/encounter from)
Quarter	Three months of the state fiscal year as broken into four quarters. July 1 through September 30 is referred to as the first quarter of the state fiscal year
Voided Encounter	An encounter previously accepted at ADHS or AHCCCS, but was voided by request from a CRS Site because the encounter was sent to ADHS in error or should not have been sent to AHCCCS by ADHS.

Related Information Resources

The CRS Contractor should use the following resources in addition to this manual:

- ADHS/OPS Tidbits Newsletter
- The ADHS/CRS Contract with each Site

- AHCCCS Encounter Resources, including
    - Encounter Reporting Manual
    - Medical Policy Manual
    - Encounter Keys and Claims Clues Newsletters
    - Technical Interface Guidelines (TIG)
- Coding Documentation
    - UB-92 Manual/UB-04 Manual
    - ICD-9-CM Diagnosis & Procedure Code Manual
    - Physicianôs Current Procedural Terminology (CPT) Manual
    - HCFA Common Procedures Coding System (HCPCS) Manual
    - First Data Bank Blue Book
    - HIPAA Guidelines via www.cms.hhs.gov/HIPAAGenInfo

Submission Schedules

Introduction:

The Office of Program Support (OPS) requires all CRS Contractors to establish and adhere to a Submission Schedule when submitting encounters to ADHS/CRS for each of the form types (HCFA, UB, Dental or Drug). In addition encounter submissions will be monitored for volume consistency. The Submission Schedule and encounter volume are monitored and scored as part of each CRS Siteôs yearly Administrative Review.

Monitoring:

OPS Representatives will monitor their respective CRS Contractorôs encounter submissions using the ñDaily enc submission rptò (attachment 1) and will include the results in the CRS site workgroup meeting agenda for discussion. OPS Representatives are to follow the procedures listed in the Encounter Acceptance Rates Policy to produce the report.

Administrative Review Scoring:

Submission Schedules are monitored as part of the CRS Contractorôs yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Encounter Acceptance Rate

Introduction:

CRS Contractors are required to maintain an encounter acceptance rate of 90% or greater. Acceptance rates are significant as they may be the first indication of possible systemic problems. The Office of Program Support (OPS) will monitor encounter acceptance rates daily. In addition, encounter acceptance rates are scored as part of each CRS Contractorôs yearly Administrative Review.

Importing Daily Encounter Acceptance Reports (ADHS process):

CRS Contractors place daily encounter files on the FTP server to be processed. The files are processed through the new day batch process on a daily basis by the Arizona Department of Health Services (ADHS) IT department. Encounter acceptance rates are calculated by the ADHS/IT Department based on the number of rejected encounters versus the number of accepted encounters. IT then will place a text file containing all of the encounter acceptance data into the ñM:\Common\Program Supportò directory (internal to ADHS) and in turn notifies OPS by email when completed. A designated OPS Representative imports the text file into the departmentsô established MS Access database. The OPS Representative then notifies the other OPS Representatives via email that the Daily Encounter Reports for a specific date have been imported to the MS Access database.

Reviewing Daily Encounter Acceptance Reports (ADHS process):

The OPS Representatives are required to review the CRS Contractorôs acceptance rates on a daily basis using the Daily Detail Encounter Acceptance Report (Attachment 1).

Analyzing Data:

OPS Representatives will examine their Contractorôs encounter submissions to ensure a minimum 90% acceptance rate is achieved for each encounter form type. For any encounter form type that does not meet the expected 90% acceptance rate, an explanation of the cause(s) is/are mandatory from the Site.

CRS Site Documentation:

CRS Sites are required to provide ADHS an explanation by email within 2 business days, when acceptance rates fall below the 90% minimum. OPS representatives will maintain this documentation by adding the explanations to the Daily Encounter Acceptance Report database. ADHS/OPS will consider systemic problems when analyzing the encounter acceptance rates.

Results:

If 90% minimum acceptance rates are not maintained for any one-form type during the period of a quarter, a letter is sent to the CRSôs CFO before the end of the quarter notifying them that they could be placed in the testing environment (See Test Criteria Section of this manual). If the Contractor continues to average below 90% acceptance rates through the remainder of the quarter, the Contractor will be placed in the test environment at the end of the quarter (see Submission Test Criteria Section).

Conditions for placing a CRS Contractor into the testing environment:

- A new contract has been awarded to a Childrenôs Rehabilitative Services. All transactions including but not limited to:
    - 837P (Professional Encounter)
    - 837I (Institutional Encounter)
    - NCPDP (Drug Encounter)
- System modifications have been implemented in CRS i.e. ñCovered Services and HIPAAò or as requested by OPS.
- The CRS Contractor fails to maintain an average 90% or greater acceptance rate on any form type for a period of one quarter
- The CRS Contractor fails to adhere to the established submission schedule for any form type for a period of one quarter.
- Submission volumes drop 50% from the number of records submitted during the previous quarter compared with the most recent quarter completed, for any form type.
- Upon removal from the testing environment due to satisfactory completion of the test criteria, a CRS Contractor may be moved back into test if any one of the first three submissions to production does not meet the expected 90% acceptance rate. The CRS Contractor will then have to achieve a 90% or greater acceptance rate on a minimum of 3 additional test files, for each form affected, before being placed back into the production environment.

Administrative Review Scoring:

Acceptance rates are monitored as part of the CRS Contractorôs yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

Daily Detail Encounter Acceptance Report

Daily Detail Encounter

Arizona Department of Health Services

Daily Detail Encounter Acceptance Report - GSA - 1/1/2007 - 3/31/2007

	Process Date	Total Enc.	Processed Enc.	Voids	Void %	Accepted	Rejected	% Accepted
DRUG								
	1/3/2007	13,211	13,211	0	0.00%	12,945	266	97.99%
	1/25/2007	13,238	13,238	0	0.00%	13,013	225	98.30%
	2/22/2007	14,936	14,936	0	0.00%	14,187	749	94.99%
	3/29/2007	12,223	12,223	0	0.00%	12,019	204	98.33%
Total		53,608	53,608	0		52,164	1,444	97.31%
HCFA								
	1/2/2007	136	0	136	100.00%	26	110	19.12%
	1/5/2007	25,767	25,510	257	1.00%	25,452	317	98.78%
	1/12/2007	12,411	12,407	4	0.03%	12,263	162	98.81%
	1/22/2007	19,986	19,986	0	0.00%	19,787	201	99.00%
	1/25/2007	13,612	13,612	0	0.00%	13,314	298	97.81%
	1/31/2007	13,215	13,215	0	0.00%	12,928	292	97.83%
	2/1/2007	310	310	0	0.00%	181	129	58.39%
	2/8/2007	16,433	16,115	318	1.94%	16,326	107	99.35%
	2/15/2007	17,650	17,343	307	1.74%	17,372	278	98.42%
	2/22/2007	24,170	24,170	0	0.00%	24,073	97	99.60%
	3/6/2007	17,968	17,967	1	0.01%	17,710	258	98.56%
	3/9/2007	13,618	13,598	20	0.15%	13,516	102	99.25%
	3/12/2007	363	362	1	0.28%	352	11	96.97%
	3/13/2007	16,217	16,217	0	0.00%	16,165	52	99.68%
	3/14/2007	318	318	0	0.00%	318	0	100.00%
	3/23/2007	16,440	15,366	1,074	6.53%	16,368	72	99.56%
	3/27/2007	669	628	41	6.13%	633	36	94.62%
	3/28/2007	17,569	16,420	1,149	6.54%	15,635	1,941	88.99%
Total		226,852	223,544	3,308		222,419	4,466	98.04%
UB								
	1/24/2007	800	800	0	0.00%	768	32	96.00%
	2/28/2007	267	267	0	0.00%	240	27	89.89%
	3/8/2007	3	0	3	100.00%	3	0	100.00%
	3/27/2007	315	315	0	0.00%	285	30	90.48%
	3/28/2007	16	16	0	0.00%	14	2	87.50%
Total		1,401	1,398	3		1,310	91	93.50%
Grand Total		281,861	278,550	3,311		275,893	6,001	97.88%

Tuesday, May 29, 2007 *Page 1 of 1*

Submission Timeliness/210 Report

Introduction:

CRS Contractors are required to submit all encounters to ADHS within 210 calendar days from the ending date of service. Failure to submit an encounter within 210 calendar days will result in an untimely encounter that will be scored as part of each Siteôs yearly Administrative Review. In addition, encounters submitted greater than 210 days may result in a timeliness error during the AHCCCS Data Validation study.

Collecting the Data (ADHS process):

The ADHS/IT department produces an encounter file that identifies all encounters submitted greater than 210 days from the end date of service. IT then places the text file containing all of the encounter data into the M:\Common\Program Support directory and notifies OPS by email when the file is ready to import. A designated OPS Representative imports the text file into the ADHSô established MS Access database. The OPS Representative then notifies the other OPS Representatives via email that the Daily Encounter Reports for a specific date have been imported to the MS Access database.

Reviewing the 210 Report:

The OPS Representatives are required to review the 210 report to identify issues CRS Contractors are submitting timely encounters. The findings of the 210 reports are a standard review item at the monthly CRS/OPS workgroup meetings.

CRS Sites are required to provide an explanation if:

- More than five percent of their encounters are submitted over 210 days.
- An increase in untimely encounters is noted.

Administrative Review:

Encounters submitted to ADHS greater than 210 days from the end date of service are evaluated and scored as part of the yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

210 Report

Arizona Department of Health Services

Greater than 210 days Summary Report - GSA -

1/1/2007 - 3/31/2007

DailyEncounter_SummaryR

	Total Enc.	Processed Enc.	Voids	Void %	Accepted	Rejected	% Accepted	210 PD	210 %
DRUG	54,030	54,030	0	0.00 %	52,586	1,444	97.33 %	270	0.51 %
HCFA	227,016	223,704	3,312	1.46 %	222,580	4,466	98.05 %	1,771	0.80 %
UB	1,401	1,398	3	0.21 %	1,310	91	93.50 %	63	4.81 %
Grand Total	282,447	279,132	3,315		276,476	6,001		2,104	

% Accepted formulas: HF=54/UB.Accepted&Rejected*100; DRUG Accepted&Total*100

Tuesday, May 29, 2007

Page 1 of 1

Aged Pended Encounters/Pend Sanctions

Introduction:

CRS Contractor must resolve all pended encounters from AHCCCS within 120 calendar days of the original AHCCCS processing date. Failure to resolve AHCCCS pended encounters within 120 days is known as an aged pended encounter and is subject to sanction, with exception to encounters that pended due to AHCCCS or ADHS error. CRS Contractors have the ability to work on correcting pended encounters through out the month.

AHCCCS Pended Encounters Cycle (ADHS process):

Monthly, AHCCCS sends a file to ADHS containing all encounters that have pended, or are still pending at AHCCCS during that monthôs adjudication cycle. When ADHS/IT receives the file, it is reviewed for errors, placed into manageable file formats, and promptly placed on the respective CRS Contractorôs FTP server.

An OPS Representative will immediately send an email to all the CRS Contractors stating that AHCCCS Pend files are available on the FTP server (Attachment 1). This email includes the deadlines of when each step of the pend corrections process is due to ADHS.
Sites are to immediately begin working the pends in order to meet all deadlines. All questions regarding the AHCCCS pended encounters should be directed to the appropriate OPS Representative.

Monitoring Pended Encounters (ADHS process):

To be proactive in reducing and/or eliminating sanctions due to aging pended encounters, OPS Representatives will work with Contractors to address encounters pended more than 90 days.

Deleting, Voiding, and Overriding of Encounters:

Pended encounters must not be deleted or voided by a CRS Contractors as a means of avoiding sanctions for failure to correct encounters within 120 days. The CRS Contractor will document all Title XIX and Title XXI encounters that have been deleted, voided, or overridden and maintain a record of CRNs with appropriate reasons for the action indicated. See Deletion/Override Log section of this manual.

Preliminary Sanctioning Process:

AHCCCS, on a quarterly basis, distributes to ADHS/OPS, via the FTP server, their preliminary findings of sanctionable aged pended encounters (Attachment 2). The preliminary findings are divided into aged pended encounters that are excluded from sanction (Attachment 3) and those that are being sanctioned (Attachment 4). A summary of all sanctionable pended encounters is also placed by AHCCCS on the FTP server for ADHS in the form of an Excel spreadsheet. The ADHS Encounter Manager or Supervisor is responsible for moving these files to the ñM:\Program Support Staff\Encounters\Pend Sanctions\ò folder. The ADHS Encounter Manager then provides each CRS Contractor with a letter defining the preliminary results and includes a CD containing the spreadsheet summary of the sanctionable aged pended encounters specific to the CRS Contractor for review and comment (Attachment 5).

Challenge Preliminary Findings:

The CRS Contractor is responsible for identifying any pends they wish to challenge in the preliminary report. Each challenge must be supported by additional documentation to include, but are not limited to:

- PMMIS screen prints
- CIS screen prints
- Screen prints from the CRS Siteôs internal system

OPS will review all challenges and determine the documentation that will be forwarded to AHCCCS for consideration in reducing sanctions.

Final Sanction Determination:

Once AHCCCS reviews all challenges and additional documentation, a final decision is made as to which pended encounters are sanctionable (Attachment 6). The sanctions are then calculated (Attachment 7) according to age category. The ADHS Office of Business Operations is notified of the final sanction amounts and funds are withheld from the sanctioned CRS Contractorôs capitation payment the following month. ADHS/OPS will send a letter to each CRS Contractor advising them of final sanction amounts (Attachment 8). Whether sanctions are waived or not, a CRS Contractor is still responsible for correcting all pended encounters unless the error is on behalf of AHCCCS or ADHS.
Sanctions are imposed according to the following fee schedule:

0 – 120 days	121 – 180 days	181 – 240 days	241 – 360 days	361 + days
No sanction	**$5 per month**	**$10 per month**	**$15 per month**	**$20 per month.**

Administrative Review Scoring:

Aged pended encounters are monitored as part of the CRS Contractorôs yearly Administrative Review. Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

AHCCCS Pends Availability and Correction Due Dates Email

IMPORTANT INFORMATION - December 2006 Pend Data

1) Pend Files are Ready
Your current pend file (APEND_rr.txt) is available on the OPS FTP server in the password protected zip file (APEND_rr.ZIP).
**Please note that your file contains all pended records (hard and soft). Do not work the soft edits.

MONTH	CRS	RECS	FTP	TO CRS
2006-12	02	6,344	Y	
2006-12	08	13,127	Y	
2006-12	15	842	Y	
2006-12	22	575	Y	
2006-12	26	3,168		Y
2006-12	27	1,245	Y	

2) Pend Reporting
Reports of all encounters pended at AHCCCS for the month of December 2006 have been generated and placed in your respective CRS directory on the FTP server.

3) Pend Processing Deadlines

A) DelDup File (AHCCCS Pend Overrides, & Subvention Deletions) **Due By: Noon 12/28/2006**
Use only the following combinations of Error and Reason Codes.

Error Code	Reason Code
	A001 Per CRS review, not a duplicate encounter
R410	D012 Recipient not AHCCCS eligible during dates of service (R410, R480)
R480	D012 Recipient not AHCCCS eligible during dates of service (R410, R480)
R660	D017 Recipient does not have MHS enrollment at AHCCCS during dates of service (R660)
H280	D018 Encounter not eligible to adjust (H280)
N027	D019 Drug not elig for Medicaid coverage (N027)

B) All other error codes should be adjudicated either through on-line correction of applicable data fields in the CRS system, or through submission of a full void transaction in the normal daily process.
All pended encounter on-line corrections and void transactions must be completed in CRS by 11:00 am 1/2/2007.

4) Pend Error Questions
Please feel free to contact your respective OPS Representative should you have any questions, or should you require any additional information.

Attachment 2

Preliminary Sanction Summary

Preliminary Sanction Summary

Quarter Ending: June, 2006

Plan ID: 079999 **Plan Name:** ADHS

TSN: 79

Age Category	Total Encounters	Sanction Amount
181-240 Days	2	$20
241-360 Days	4	$60

TSN: 80

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	$5
241-360 Days	4	$60

TSN: 81

Age Category	Total Encounters	Sanction Amount
121-180 Days	4	$20
181-240 Days	3	$30

TSN: 84

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	$5

Plan Total	Total Encounters	Sanction Amount
	19	$200

Tuesday, August 01, 2006 Page 1

Attachment 3

Pended Encounters Excluded from Preliminary Sanctions

Summary of Encounters Excluded From Preliminary Sanctions

Quarter Ending: *June, 2006*

Plan ID: *079999* ***Plan Name:*** *ADHS*

Error Code	*Error Description*	*Form Type*	*TSN*	*Total*
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	A	79	6
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	A	80	90
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	I	93	12
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	I	79	28
P210	IHS SERVICE PROVIDERS ARE FEE FOR SERVICE ONLY	A	81	78
P210	IHS SERVICE PROVIDERS ARE FEE FOR SERVICE ONLY	A	80	295
P340	PROVIDER SPECIFIC RATE NOT ON FILE FOR DOS	I	79	2
P340	PROVIDER SPECIFIC RATE NOT ON FILE FOR DOS	I	93	3
P353	RATE NOT FOUND ON PROV TYP TBL	I	79	6
R410	RECIPIENT NOT ELIGIBLE FOR AHCCCS SERVICES ON SERVICE DATES	A	80	1
R480	RECIPIENT NOT ENROLLED ON SERVICE DATES	C	81	6
R600	MEDICARE COVERAGE INDICATED BUT NOT BILLED	A	81	12
R600	MEDICARE COVERAGE INDICATED BUT NOT BILLED	A	83	36
R632	MEDICARE APPROVED AND PAID NOT BOTH PRESENT	A	83	2
V151	OR RM BILL-ICD9 AND/OR HCPCS MUST = SURGICAL	I	79	6
V152	OR RM BILL-NO SURG ICD9 AND/OR HCPCS CODE PRESENT	I	79	3
Z610	EXACT DUPLICATE FOUND	I	79	6
Z615	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	I	80	1
Z615	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	I	79	6
Z620	NEAR DUPLICATE FOUND	I	93	2
Z720	EXACT DUPLICATE FOUND	A	81	4
Z720	EXACT DUPLICATE FOUND	A	83	8
Z720	EXACT DUPLICATE FOUND	A	79	12
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	83	1
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	79	58
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	93	210
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	80	272
Z745	NEAR DUPLICATE FROM DIFFERENT HEALTH PLANS	A	80	3
Z745	NEAR DUPLICATE FROM DIFFERENT HEALTH PLANS	A	93	12
Z760	NEAR DUPLICATE FOUND - FROM-THROUGH DATES OVERLAP	A	81	1
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	94	8
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	84	47
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	83	129
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	93	352
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	79	510
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	80	6,505
Plan Total				8,733

Thursday, July 27, 2006 *Page 1*

Attachment 4

Preliminary Encounter Sanctions Error Summary

Preliminary Encounter Sanctions Error Summary

Quarter Ending: *June, 2006*

Plan ID: *079999* ***Plan Name:*** *ADHS*

Error Code	*Error Description*	*Form Type*	*Total*
D010	PRIMARY DIAGNOSIS NOT ON FILE (FOR DOS)	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	1
N004	NDC CODE NOT ON FILE	C	1
N004	NDC CODE NOT ON FILE	C	5
R660	DHS MHS ENC RCP MUST BE ON MHS ENROLL	A	4
T005	PSYCH BED W/OUT PSYCH DX-INVALID	I	1
V020	REVENUE CODE NOT ON FILE FOR DOS	I	1
V045	NO ACCOMMODATION BILLING - BILL IS I/P OR LTC	I	4
Plan Total			19

Thursday, July 27, 2006 *Page 1*

Attachment 5

Preliminary Sanction Letter Sent to CRS Sites

[Date]

[Recipient]
[CRS Site]
[Address]
[City, State Zip]

Dear [Dr./Mr. or Ms.] [Recipient]:

The purpose of this letter is to inform you of the preliminary results of sanctionable pended encounters for the quarter ending [month, year]. According to your contract, [CRS Site] is required to resolve all pended encounters within 120 calendar days of the original processing date.

Enclosed is a diskette with a spreadsheet and the summary reports of your sanctionable pended encounters for the quarter ending [month, year] including preliminary sanction amounts. Please enter your responses to any items believed not to be sanctionable into the designated area of the spreadsheet. Return the diskette and any supporting documentation to the Office of Program Support Encounter Unit, attention Kevin Gibson. If we do not hear from you by [Month Day, Year], we will use the preliminary results as the final sanction amount. The Arizona Department of Health Servicesô Encounter Unit will evaluate and, if appropriate, submit a challenge to AHCCCS for final review.

Should you have any questions regarding this matter, please feel free to contact me at (602) 364-4727.

Sincerely,

[Name], Eligibility/Encounter Manager
Bureau of Financial Operations

Enclosures

c: [Name], Deputy Director, ADHS
[Name], Chief Financial Officer, ADHS
[Name], Program Support Manager, ADHS
Contract Compliance File

Attachment 6

Error Summary Final

Error Summary Final

Quarter Ending: *June, 2006*

Plan ID: *079999* ***Plan Name:*** *ADHS/*

Error Code	*Error Description*	*Form Type*	*Total*
D010	PRIMARY DIAGNOSIS NOT ON FILE (FOR DOS)	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	2
N004	NDC CODE NOT ON FILE	C	6
R660	DHS MHS ENC RCP MUST BE ON MHS ENROLL	A	2
T005	PSYCH BED W/OUT PSYCH DX-INVALID	I	1
Plan Total			12

Wednesday, November 01, 2006 *Page 1*

Attachment 7

Final Sanction Summary

Final Sanction Summary Quarter Ending: June, 2006

Plan ID: **079999** **Plan Name:** **ADHS/**

TSN: 79

Age Category	Total Encounters	Sanction Amount
181-240 Days	1	$10

TSN: 80

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	$5
241-360 Days	2	$30

TSN: 81

Age Category	Total Encounters	Sanction Amount
121-180 Days	4	$20
181-240 Days	3	$30

TSN: 84

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	$5

Plan Total	Total Encounters	Sanction Amount
	12	$100

Wednesday, November 01, 2006 Page 1

Attachment 8

Final Sanction Letter Sent to CRS Contractors

[Date]

[Recipient]
[CRS Site]
[Address]
[City, State Zip]

Dear [Dr./Mr./Ms.] [Name]:

The purpose of this letter is to inform you of the final results of sanctionable pended encounters for the quarter ending [Month, Year].

In a letter dated [Month Day, Year], [CRS Contractor] was provided an opportunity to review the preliminary results, and provide input to items believed to be sanctioned in error. AHCCCS has completed their review of the errors [Enter amount of sanction or amount waived] for all aged pended encounters for this quarter.

Please note that, when sanctions are waived, the CRS Contractor is still liable for correcting all pended encounters unless the error is due to an AHCCCS error.

Should you have any questions regarding this matter, please contact [Name], Encounter Unit Manager at (602) [phone number].

Sincerely,

[Name]
Chief Financial Officer

c: [Name], Deputy Director, ADHS
[Name], Program Support Manager, ADHS
Contract Compliance File, ADHS
OPS Representatives, ADHS

Deletion/Override Log

Introduction:

ADHS/OPS requires each CRS Contractor to maintain and submit a quarterly reconciliation log of all encounters that have been overridden, deleted, or voided from the AHCCCS PMMIS system. The quarterly Deletion and Override logs are scored as part of the yearly Administrative Review.

Deletion and Override Log Contents:

The CRS Contractor is required to maintain a log of all deleted, overridden, or voided encounters from the AHCCCS PMMIS system. The quarterly logs must be submitted in accordance with the following schedule.

Submitting Deletion and Override Logs:

The CRS Contractor is required to submit the Deletion/Override log to OPS no later than the 30th of the month following the end of the quarter. For example, for quarter ending March 31, 2007, the report is due by April 30, 2007. One week prior to the end of each quarter the OPS Representatives will send an email to each Contractor stating that the Deletion and Override log is due to OPS. If the 30th of the month falls on a holiday or weekend, the OPS Representative will advise the Site of any extension. The CRS Site will submit the Deletion and Override log to the FTP server according to the required Deletion and Override Logs File Layout (Attachment 1). The CRS Contractor will send an email to their OPS Representative and will copy the Encounter Supervisor when the logs have been placed on the FTP server. Once the OPS Representative receives the email from the Contractor stating that the Deletion and Override log is available, the file will be reviewed for accuracy.

Quarterly Deletion/Override Log Submission Schedule

Review Quarter	Due Date At ADHS/OPS
Ending March 31	April 30
Ending June 30	July 30
Ending September 30	October 30
Ending December 31	January 30

Comparing Deletion and Override Logs for Accuracy:

ADHS/IT department keeps a file of each CRS Contractorôs voided or deleted encounters and will add in all override requests. This file is made available to OPS and then compared to the CRS Siteôs submitted log. The system will compare each encounter in the ADHS IT file to the Deletion/Override log submitted. The system will use the following criteria to compare the logs:

- **ICN/Line Number/CRN**: The CRS ICN, line number and CRN must match the ADHS Deletion and Override file's ICN, line number and CRN for each encounter.
- **Provider ID**: The Provider ID must match the record's Provider ID for each encounter if applicable. The identification number provided must match the original submission.
- **NPI**: The National Provider Identifier must match the record's National Provider Identifier for each encounter. The identification number provided must match the original submission
- **Start/End Date**: The start date and end date must match the records start and end date for each encounter.
- **Error 1**: If the encounter originally pended at AHCCCS, the error should be reported and must match the record's Pended Encounter History Error 1 record for each encounter.
- **Client ID**: The Client ID must match the record's Client ID for each encounter.
- **Reason Code**: If there was a Reason Code submitted for the deletion or override of an encounter from AHCCCS, it must appear in the log and must match the record for each deleted encounter. CRS Contractors must use one of the OPS approved reason codes. (Attachment 2)
- **Record Missing**: If a CRS Contractor's Deletion and Override log is missing encounter records in comparison to the ADHS Deletion and Override file, the number of missing records will be calculated.

Findings:

Upon completion of a CRS Contractor's Deletion and Override log review, the results will be provided to the OPS Representative. An e-mail will then be sent to the CRS Contractor, by the assigned representative, identifying any errors that have been discovered as well as a final score for that quarter's Deletion and Override log.

Administrative Review Scoring:

Submissions of Deletion/Override Logs are monitored as part of the yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Attachment 1

Deletion and Override Log

File Name: Enc_Recon_log MMDDYYY_CRS_ID
Format: comma quote delimited file

Claims and Encounters
Deletion and Override Log
Record Layout

Field Name	Type	*Remarks*
CRN	X(14)	
ICN Number	X(11)	
Line Number	X(2)	
Procedure NDC Revenue Code	X(11)	
Units	Number (7,1)	
CRS ID	X(2)	
Provider ID Number	X(6)	Must match original submission
National Provider Identifier (NPI)	X(10)	Must match original submission
Service Begin Date	DATE	MM/DD/YYYY
Service End Date	DATE	MM/DD/YYYY
Error Code 1	X(4)	
Error Code 2	X(4)	
Error Code 3	X(4)	
Error Code 4	X(4)	
Type	X(1)	V = Void Transaction
		D = Pend Delete
		O = Pend Override
Client ID	X(10)	
AHCCCS ID	X(9)	
Form Type	X(1)	A-HCFA, B-UB, C-DRUG
Deletion Override Reason	X(4)	
Deletion Override Description	X(200)	

CRS Sites must maintain a log containing the fields listed above for every encounter that is deleted, voided or overridden from the PMMIS system at AHCCCS.

Attachment 2

Approved Override Code:

A001	Per CRS review, not a duplicate encounter

Approved Deletion Codes:

D012	Recipient not AHCCCS eligible/enrolled during dates of service (R410, R480)
D017	Recipient does not have MHS enrollment at AHCCCS during dates of service (R660)
D018	Encounter not eligible to adjust (H280)
D019	Drug not eligible for Medicaid coverage (N027)
DITS	Per CRS request deleted by ADHS/IT
DOPS	Per CRS request deleted by OPS

Overpayment/Underpayment Log

Introduction:

CRS Regional Contractors are required to utilize the Overpayment and Underpayments Tracking Log (see example below) and the results of audited adjudicated claims to analyze the causes of processing errors, overpayments, and underpayments and develop and implement interventions to reduce the number and causes of errors, overpayments, and underpayments.

The Overpayment/Underpayment log must be submitted to the Office of Program Support on a quarterly basis. The Overpayment/Underpayment log can be found on the ADHS website at http://www.azdhs.gov/phs/ocshcn/crs/crs_policy_az.htm

Example:

ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS
CHILDREN'S REHABILITATIVE SERVICES

Claims Overpayments and Underpayments Log

REGIONAL CLINIC
MONTH/YEAR

Original CRS Claim #	Provider Last Name	Provider First Name	Provider ID	Initial Claim Paid Date	Indicator of Overpayment (OP) or Underpayment (UP)	Date OP/UP Identified	Method of Overpayment Recoupment	How Underpayment was Resolved?	Subsequent CRS Claim # assigned in Resolution	Date Overpayment / Underpayment Resolved	Amount of Overpayment / Underpayment	Reason for Overpayment or Underpayment

OPS/CRS Workgroups

Introduction:

In an effort to maintain consistency throughout the Office of Program Support (OPS), the following meeting guidelines should be used for the OPS/CRS Encounter Workgroup Meetings.

Workgroup Meeting Scheduling:

OPS/CRS Encounter Workgroup Meetings are to be held on a monthly basis with each CRS Contractor scheduled during a separate week from the other Contractors but in conjunction with the CRS Contractor meeting for out of town sites.

Agendas:

- The agenda should be completed by the OPS Representative using the **Meeting Agenda/Minutes Template** (Attachment 1)
- It is everyoneôs responsibility to research any agenda item submitted as soon as it is presented. Accepting only a topic and adding it to the agenda is insufficient, the OPS Representative should also document the specific questions the CRS Contractor has regarding the topic.
- When an edit reason is discussed, the OPS Representative **must** include the description of the edit along with the edit number. Additionally, any time a number is used to identify an item the written description must be given.
- One week before the meeting, the final agenda should be distributed by the OPS representative.
- Workgroup agendas **must** be completed by the OPS representative at least one day prior to the date the agenda is due so that it may be reviewed and approved by an ADHS supervisor or manager.

Before the Workgroup Meeting:

Once a final Workgroup agenda has been distributed, the OPS Representative is responsible for hosting an internal meeting, known as a pre-briefing, to inform all ADHS parties that will be attending the Workgroup of all issues to be discussed. Any clarification of an issue should be made at this time.

Conducting the Workgroup Meeting:

- Before the Workgroup meeting begins, the OPS Representative will prepare enough copies of the following items for hand out to all persons in attendance:

  ✓ Agenda
  ✓ 210 Report

✓ Aged Pends Report

- A sign-in sheet must be completed for <u>every</u> Workgroup meeting. The following is an example of the sign-in sheet:

Eligibility, Enrollment, and Encounter Workgroup

OPS/Appropriate RBHA

Date

NAME	SIGNATURE	Agency	Phone number

- Workgroup Meetings can be recorded, but the tapes are only to be reviewed in extreme cases for clarification if a situation necessitates. The OPS Representatives should rely heavily upon their notes taken during the Workgroup and de-briefing to produce the minutes.

- The Workgroup will be conducted in the order the agenda (Attachment 1) is written. The order is as follows:

Old Business:

Old Business items should be discussed first. If an old item has not been resolved a detailed explanation (update) of what has been done to correct the situation should be documented and discussed. When addressing an ñOld Businessò item, refer to the person previously documented as being responsible for follow up, and ask for an update.

Standard Issues:

- ✓ *Daily Submission Report* ï Provided to advise of the acceptance rates and to ensure the acceptance rate stays at 90% or greater. OPS Representatives should include any comments sent by the CRS Site to explain instances where the acceptance rate was not 90%.

- ✓ *210 Report* ï Provided to identify claims submitted by CRS past the 210 day filing time requirement.The agenda should display the findings from the current and previous report.

- ✓ *Aged Pends-Report* ï Provided to advise of the number of pends that have exceed or are getting close to the 120-day limit.

- ✓ *Intakes without Demographics Report* ï Provided to advise of the number of intakes currently in the system without a demographic.

- ✓ *Override/Delete Log Request* ï Advise of upcoming due dates for the Override/Delete Log submissions.

- ✓ *Data Validation Update* ï Advise of any data validation results and of any upcoming due dates.

- ✓ *Training* ï Inquire if any training has taken place since the last meeting. If the CRS Contractor has conducted training, request a summary of the training content and a copy of the sign-in sheet.

New Issues:

New Issues should be logged with the date presented and the person assigned to do the research/follow-up. These issues should be researched immediately after the meeting not just before the next scheduled meeting. If the issue/problem is resolved prior to the next meeting the OPS Representative should contact the CRS Site to advise and update the information on the next agenda. The issue can be closed at the next meeting if the CRS Site agrees.

Closed Issues:

Closed Issues may be removed immediately after both the CRS and OPS agree that the issue is resolved. Closed items should be moved to the Closed Items Log (Attachment 2) for the CRS Site. OPS Representatives are to bring at least one copy of the Closed Items Log to each Workgroup meeting.

Following the Workgroup:

Following a Workgroup meeting, OPS Representatives are to immediately begin documenting all discussions from the Workgroup known as minutes.

Minutes:

Minutes shall be completed using the **Agenda/Meeting Minutes Template** (Attachment 1). Meeting minutes must be discussed the day of or the day after the Workgroup at a De-briefing meeting (internal to ADHS). The De-briefing is the forum that is used to clarify any discussions that took place during the Workgroup meeting. The OPS Representative is responsible for scheduling and hosting this meeting. Typed minutes are due to the supervisor or manager two (2) business days after the Workgroup. Upon review and approval by a supervisor or manager, the meeting minutes are to be distributed to the attendees no later than three (3) business days from the date of the meeting.

Attachment 1

CRS Site /Office of Program Support Meeting _____
Enter Agenda or Minutes Above

Created Date:
Final Date:

Current Meeting Date
Place
Time

Attendees:

CRS Site OPS: Absent:

Issue:	*Date reported:*	*Discussion:*	*Action:*	*Assignment:*
Old Business:				
Standard Issues:				
Daily Submission Report				
210 Report				
Aged Pends				
Intakes w/o Demographics Report				
Submission Schedule				
Override/Delete Logs, Due Date				
Check Register, Due Date				
Data Validation Update				
Training				
NPI				
Encounter Withhold				
New Business				
Next Meeting:				

Next Meeting Date
Place
Time

Page 1 of 1

Attachment 2

CRS Site /Office of Program Support
Closed Items

Issue:	*Date Reported:*	*Date Closed:*	*Discussion:*	*Action:*	*Assignment:*

Edit Alert

Introduction:

An Edit Alert is the method used by the Office of Program Support (OPS) to notify the CRS Contractors of system changes that may impact them.

Notifying CRS Contractors of System Changes:

Whenever possible the OPS send notification out 90-days prior to the implementation of system modifications. There may be instances when the 90-day notification notice is not possible i.e. legislative requirements or emergency production corrections. If one of these situations occurs, the CRS Contractor will be notified as soon as possible. These notifications will be communicated thru Edit Alerts, and reiterated during Encounter Workgroup meetings and in the monthly Tidbits.

Create and Distribute the Edit Alert (ADHS process):

Once an SSR is written for a system modification, and the originator has obtained all of the required signatures, the original yellow SSR will be delivered to the ADHS/IT Department and a copy will be delivered to the OPS Encounters Unit Supervisor and the Testing Coordinator.

It is the responsibility of the ADHS Testing Coordinator to draft an Edit Alert. The Edit Alert contains the following:

- The system change
- Scenarios (if applicable)
- The SSR number and description
- The expected implementation date

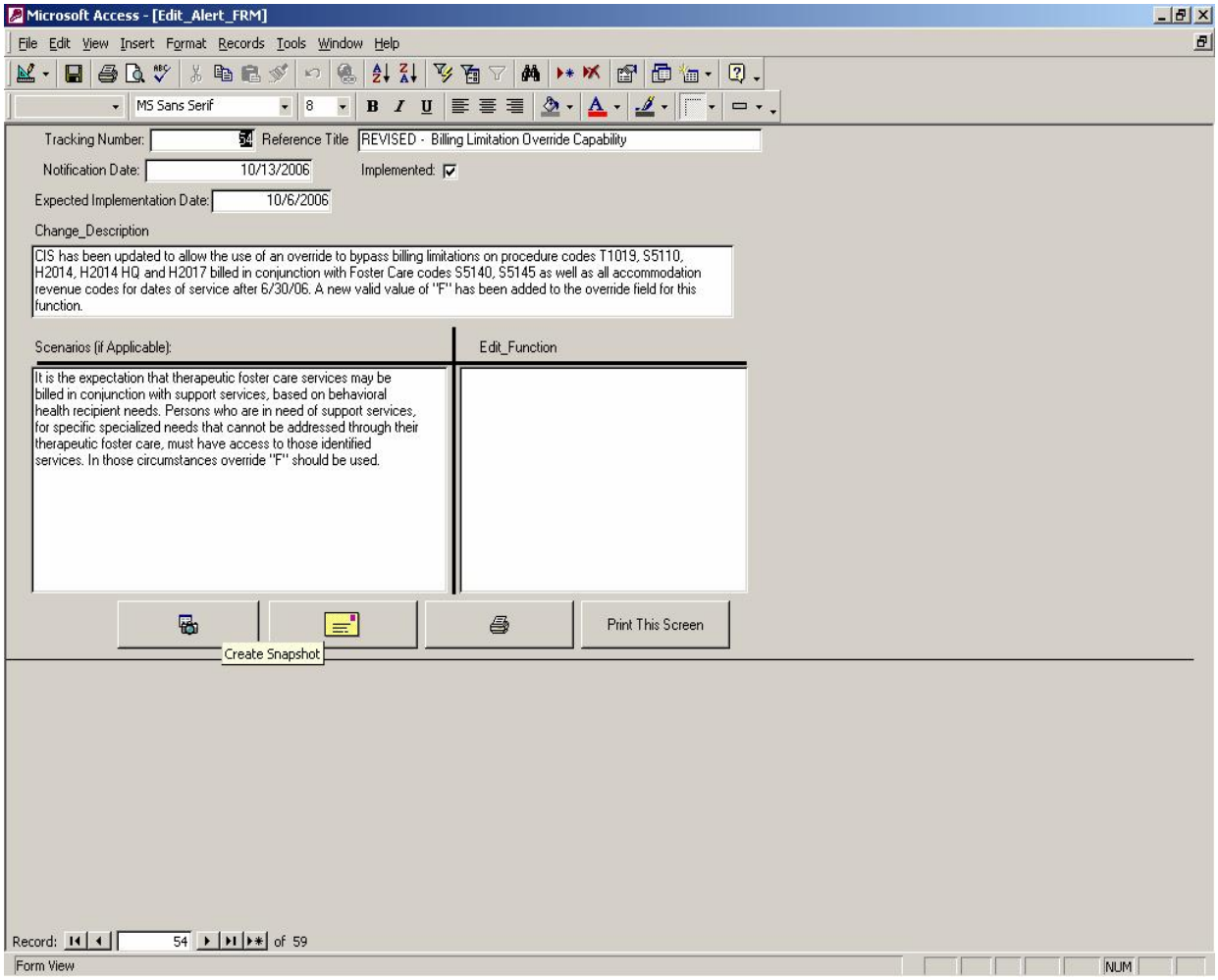
The completed Edit Alert is e-mailed to the CRS Contractor and distributed to OPS and ADHS/IT staff. A second Edit Alert will be e-mailed to advise the CRS Contractor that testing of the change has been completed (if required) and the exact date production will be updated.

Implementation

Once implementation takes place, an Edit Alert will be emailed to advise the CRS Contractor of the exact date production will be updated.

Attachment 1

Edit Alerts Database



Attachment 2

Sample Edit Alert

New/Changed Edit Alert

Tracking_Number: 69 **Implemented:** ☐

Reference Title Demographic - AXISIII Field Change

Notification Date: May 25, 2007

Expected Implementation Date: July 1, 2007
ADHS will provide the RBHA's with 90 days notice when possible

Change Description: Establish a field that stores behavioral health recipient's current medical diagnoses. (SSR 2178)

The current data set submitted by the T/RBHA to BHS utilizes five 2-byte fields, which indicate a generic category of the recipient's current medical condition(s). ADHS must identify whether the behavioral health recipient reports as having any of 36 AHCCCS-specified diagnoses.

The new field will identify specified conditions of behavioral health recipients for which coordination of care should be provided. The Coordination of Care performance measure and other potential analysis will be extrapolated through examination of this data.

The existing AXISIII field(s) will remain in the data set, but field-specific edits for records with an intake date of MM/DD/YYYY (system change date) or later will be ignored/modified. Data submissions with an intake date of MM/DD/YYYY (system change date) or later will not require completion of the existing AXISIII field(s).

The new field will store up to three 2-byte codes. A maximum of three unique codes may be stored per individual record. Either Not Applicable (N/A) or a valid code must be entered. If N/A is entered as the first of the 3 possible entries, then N/A must also be entered for subsequent entries. Exact codes, other than N/A, cannot be repeated in an individual record. If more than one field is completed with any valid value other than N/A the codes must be unique.

This change will enable ADHS/DBHS to be more in sync with AHCCCS' system and will decrease the number of encounters pending at AHCCCS.

Special Day Runs

Introduction:

The Office of Program Support (OPS) recognizes that there may be occasions when there will be a need to submit encounters separate from the normal submission. These types of submissions are considered special day runs and can be utilized to test changes made to the CRS Contractorôs system or to isolate a specific group of encounters. In addition, encounter form type(s) that have been restricted to the test environment, special day runs will be the only form of submission until the test criteria has been satisfactorily met.

Request Process:

Special day runs will only be performed by ADHS on Wednesdays. The CRS Contractor must coordinate with their OPS Representative to schedule a special day run. The following are the procedures that must be performed:

- The CRS Site must submit an electronic request, by Noon on Tuesday, including encounter volumes and specific details of what is being submitted and why.
- The OPS Representative will review the request with the appropriate OPS management.
- The OPS Representative will notify the CRS Site electronically of the request approval or denial by COB Tuesday.
- If the request is approved the OPS Representative will copy the ADHS/IT department to alert them that a special day run will be submitted the next day.

Processing the Special Run Day:

To successfully complete the special day run request the CRS Contractor must:

- Ensure files are not placed on the FTP server prior to Wednesday morning (files placed on the server prior to Wednesday morning risk being picked up by the nightly processing)
- Ensure the files are submitted to the FTP server by 10:00 a.m. on Wednesday

Correct Reporting of Ancillary Charges

Incorrect Billing

UBs submitted in this manner will fail CIS pre-processor edit, N228 UB ancillary line with zero/blank units or dollars.

Line	Rev Cd	Units	Billed	NonCovChg	Paid	Description
01	134	5	2960.00	000.00		Psych/3&4 Bed
02	251	1	0.00	000.00		Drugs/Generic
03	301	32	0.00	000.00		Lab/Chemistry
04	302	1	0.00	000.00		Lab/Immunology
05	305	1	0.00	000.00		Lab/Hematology
		Total	**2960.00**		**2960.00**	

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	134	5	3650.00			Psych/3&4 Bed
02	251	1	450.00			Drugs/Generic
03	301	32	400.00			Lab/Chemistry
04	302	1	150.00			Lab/Immunology
05	305	1	150.00			Lab/Hematology
		Total	**4800.00**		**2960.00**	**Total paid for entire claim**

Correct Billing

The providers should bill UBs to the CRS Contractors exactly as they would bill any private insurance carrier. Ancillary revenue codes, units, and amounts must be reported on all inpatient UBs. The rates reported should not be the contracted amount or the amount the CRS Contractor is expected to pay but the actual amount of the service. The CRS Contractor will report their contracted amount for the service in the paid field.

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	134	5	3650.00	690.00		Psych/3&4 Bed
02	251	1	450.00	450.00		Drugs/Generic
03	301	32	400.00	400.00		Lab/Chemistry
04	302	1	150.00	150.00		Lab/Immunology
05	305	1	150.00	150.00		Lab/Hematology
		Total	**4800.00**		**2960.00**	**Total paid for entire claim**

Correct Reporting of Same Day Admit/Discharge Encounters

Inpatient encounters for clients who are admitted and discharged on the same date will be allowed for ancillary services only. These UB92/UB04 inpatient encounters with the same start and end date must be submitted as follows:

Line	Rev CD	Units	Billed	NonCov Chg	Paid	Description
01	134	1	1200.00	1200.00	0.00	Psych/3&r Bed
02	251	1	450.00	0.00	450.00	Drugs/Generic
03	301	32	400.00	0.00	400.00	Lab/Chemistry
04	302	1	150.00	0.00	150.00	Lab/Immunology
05	305	1	150.00	0.00	150.00	Lab/Hematology
		Total	2350.00		1150.00	Total paid for claim

Duplicate Encounter Logic

Introduction:

ADHS/OPS has system edits in place to prevent exact duplicate encounters from being accepted into CRS. In addition ADHS/OPS has potential duplicate edits that require review and intervention on the part of the CRS Contractors. Duplicate logic is applied to an encounter when another encounter exists in the database or on the file being submitted by the CRS Site. The following are the logic used in these edits for each form type

Exact Duplicate Logic:

UB92/UB04 will reject when the fields listed below are the same

- Client ID
- Provider ID
- Dates of service
- First 2 digits of bill type

1500 will reject when the fields listed below are the same

- Client ID
- Provider ID
- Service/Procedure Code
- Date of service
- Modifier
- Place of service

Pharmacy/NCPDP will reject when the fields listed below are the same

- Client ID
- Provider ID
- NDC
- Dispense date

Potential Duplicate Logic:

Two additional edits exist that use similar logic to the duplicate logic and when failed will require review and intervention by the CRS Site. There are no override capabilities available for these edits.

1500 will reject when the fields listed below are the same

- Client ID
- Provider ID
- Service/Procedure Code
- Modifier
- Place of service

However, dates of service are overlapping

- Fail N254-overlapping dupe in file
- Fail N255-overlapping dupe in database

Pharmacy/NCPDP will reject when the fields listed below are the same

- Client ID
- NDC
- Dispense date

However, provider is different

- Fail N256-NDC/different provider in file for date of service
- Fail N257-NDC/different provider in database for date of service

CRS Resync Requests

Introduction:

The Office of Program Support recognizes that there may be occasions when a CRS Contractors will need to have a file of all data as reflected in the ADHS computer system. This type of request is called a ñresyncò and may be utilized by the CRS Contractors for the purpose of performing reconciliation or due to processing problems.

Request Process:

The CRS Contractors must coordinate with their OPS Representative to schedule a ñresyncò by sending an e-mail to their OPS Representative and copying the ADHS Encounter Manager with the request. The Request must contain the following information:

- CRS Contractorôs name
- Type of resync(s) requested:
  - ✓ AHCCCS Eligibility
  - ✓ Encounter
- Date range:
  - ✓ Fiscal year (July 1 ï June 30)
  - ✓ Calendar year (January 1 ï December 31)
  - ✓ Any other time increment (quarter, month, etc.)

The OPS Representative will forward the e-mail notification to the identified ADHS/IT contact and will copy ADHS/IT Management.

Request received prior to 2:00 p.m. should be completed in approximately 2 ï 4 hours. Requests received after 2:00 p.m., files will not be made available until the next day.

The OPS Representative will be notified by ADHS/IT when the files are available on the FTP Server. The OPS Representative will then notify the C CRS Contractors via e-mail with the file names.

OPS/CRS Contractor Data Validation Review

Introduction:

The purpose of the data validation site review is to evaluate the process of the CRS Contractor to ensure they are accurately, thoroughly, and timely reporting their encounters. Additionally, it is an opportunity for ADHS/OPS to perform a data validation study with the contractors similar to the yearly AHCCCS study.

A data validation representative from ADHS will perform one site review; per quarter; per Site. It is the CRS Contractorôs responsibility to select the members to be reviewed.

Sample Selection Process:

ADHS/OPS will review fifty (50) medical record charts per review. The Site is responsible for randomly selecting the medical records to be reviewed and making sure the records are available at the time of the review.

The CRS Contractor is required to provide OPS, when requested, a complete schedule of available dates for the review at least **30** business days prior to the beginning of the review quarter.

Quarterly Data Validation Review Schedule

Review Quarter	Dates of Service Reviewed
Ending March 31	July, August & September of previous year
Ending June 30	October, November & December of previous year
Ending September 30	January, February & March of current year
Ending December 31	April, May & June of current year

Example: In June 2006 the quarterly review will be for services provided in October, November and December of 2005.

Site Review:

OPS will review the medical records pulled by the contractor, each medical service will be reviewed and coded by the OPS Data Validation Representative. The service code, place of service, modifier, number of units, and diagnosis code will be documented on the *ADHS/OPS Data Validation Site Review Summary* spreadsheet (Attachment 1) as the appropriate code for the services documented by the provider. OPS will review medical record findings with the Site prior to completing the Review.

After the on-site visit, the ADHS data validation unit will review the encounters on file in the CRS system to determine if the claims have been submitted and verify that there are no discrepancies between the service codes, place of service, modifier, number of units, and diagnosis codes documented in the medical record and the encounter data.

ADHS/OPS CRS Data Validation Review Summary																												
Site Reviewed:									Date Of Review:																			
			Per Audit						Per CRS									Error		Correctness Error					Pricing		
Member Name/ Member ID	DOB	Provider ID	DOS	Service Code	Modifier	Place of Service	Units	Diagnosis Code	ICN	DOS	Service Code	Modifier	Place of service	Units	Diagnosis Code	Received Date	Omission	Timeliness	Service Code	Modifier	Place of Service	Units	Diagnosis Code	Billed Amount	Paid Amount	Comments		

Completion of Spreadsheet:

There are five sections of the Data Validation Site Review spreadsheet that will be completed by the Data Validation Representative. The sections are Per Audit, CRS System, Contract Review and Errors Found.

Per Audit- to be completed on site during the Site Review:

- Client name and ID, enter from the medical records.
- Date of Birth (DOB), enter from the medical records.
- Provider ID, enter from the medical records.
- Date of Service (DOS), review medical records and indicate the dates of the services within the review period.
- Service Code, review medical records and list the appropriate service code for the description provided.
- Modifier, review medical records and list the appropriate modifier for the description provided.
- Place of Service, review medical records and list the appropriate place of service code for the description provided.
- Units, review medical records and list the appropriate units for the service description provided.
- Diagnosis Code, review medical records and list the appropriate diagnosis code for the description provided.

Per CRS- using the Children's Rehabilitative Services System the Data Validation Representative will complete after returning to ADHS. Entering the client, provider and date of service information the representative will see a list of all the services received as encounters.

- ICN, list the internal control number assigned to the located encounter
- DOS, list the date of service as it was submitted to CRS on the encounter.
- Service Code, list the service code as it was submitted to CRS on the encounter.
- Modifier, list the modifier as it was submitted to CRS on the encounter.
- Place of Service, list the place of service as it was submitted to CRS on the encounter.
- Units, list the units of service as it was submitted to CRS on the encounter.
- Diagnosis Code, list the diagnosis code as it was submitted to CRS on the encounter.
- Recd Date, list the received date of the appropriate encounter as it was submitted to CRS.

Rate Review- Data Validation Representative will complete after returning to ADHS. Entering the contracted amount for the services provided as identified by the CRS Contractor and the amount paid on the encounter.

- Rate identified in contract, list the contracted amount per service provided
- Rate on encounter, list the billed amount on each encounter found

Error Found-this section will be used to indicate any error found when the Per Audit section is compared to the Per CRS section.

- Omission, an omission error will be called when a service is identified in the medical record but is not found in CRS.
- Timeliness, a timeliness error will be called when the received date in CRS is greater than 210 days from the last day of the month in which the service was rendered.
- Correctness/Service Code, a service code correctness error will be called when the service code from the medical record does not match the service code in CRS. A correctness error on the service code includes the modifier and place of service.
- Correctness/Diagnosis, a diagnosis code correctness error will be called when the diagnosis code does not match the diagnosis code in CRS.
- Correctness/Units, a units error will be called when the do not match the units in CRS.
- Non-billable, a non-billable error will be called when documentation is found in the chart that does not substantiate a billable service or when an encounter is found in CRS but documentation was not found in the chart.
- Comments, the comments section will be used to further explain any errors or additional findings from the review. The comments will also indicate if the error is also in the CRS system.

After the Site Review:

Within five business days after the Site Review, the Data Validation Unit will prepare and issue a summary of the site review to include the number of records reviewed, the number of errors found, the review score, any training issues identified, and if required, requests for corrective action. ADHS will give the CRS Contractors a date by which the omission errors must be submitted. The CRS Contractors will also be required to correct and resubmit the correctness errors by that same date. The Data Validation Representative will copy the CRS Representatives on all correspondence.

Type of Error	Number Reviewed	Number of Errors	Error Rate
Correctness: Service Code			
Correctness: Modifier			
Correctness: Place of Service			
Correctness: Units			
Correctness: Diagnosis Code			
A single encounter may have more than one correctness error, however the encounter will only be counted once in the total calculation			
Timeliness			
Omission			
	Encounter Total	**Encounters w/Errors**	**Error Rate**
Total			

The CRS Contractors has 30 days to review the response and either address or challenge the findings or provide information on when ADHS can expect all corrections to be completed. The ADHS data validation unit will review the response submitted by the CRS Contractors who will then be notified, within 2 business days, if the plan is accepted. If the response is a challenge, the Data Validation Representative reviewing the challenge must provide a response to the CRS within 5 business days.

Providing Information:

Monthly, the Data Validation Representative will provide the OPS Representative with an update. It will be the responsibility of the OPS Representative to copy the Data Validation Representative on the ñcall for agenda itemsò that is sent to the CRS Contractors prior to the monthly workgroup meeting. At that time it will be the Data Validation Representatives responsibility to provide the update, which will include any outstanding responses due from the CRS Contractors as well as a status on any ADHS deliverables. In addition, the Data Validation Representative will advise the CRS Contractors of any AHCCCS activity.

If fraud is suspected at any time during the ADHS/OPS Site Review, the suspected fraud will be reported to the ADHS Corporate Compliance Officer.

DV Site Review Attachment 1

ADHS/OPS CRS Data Validation Review Summary

Site Reviewed: Date Of Review:

Member Name/ Member ID	DOB	Provider ID	Per Audit						Per CRS								Error		Correctness Error					Pricing		Comments
			DOS	Service Code	Modifier	Place of Service	Units	Diagnosis Code	ICN	DOS	Service Code	Modifier	Place of service	Units	Diagnosis Code	Received Date	Omission	Timeliness	Service Code	Modifier	Place of Service	Units	Diagnosis Code	Billed Amount	Paid Amount	

AHCCCS Study

Introduction:

The Centers for Medicare and Medicaid Services (CMS) requires AHCCCS to oversee and submit progress reports on the encounter data collection process. AHCCCS performs yearly data validation studies to meet this requirement. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition to meeting the CMS requirement, the data validation studies enable AHCCCS to monitor and improve the quality of encounter data.

Sample Selection Process:

The sample size for each contractor is re-calculated each year. The size is determined using the detailed ñRandom Sample Calculationò methodology documented in the *AHCCCS Encounter Data Validation Technical Document*. The sample size indicates the number of encounters/services AHCCCS intends to review for the data validation study.

Medical Record Collection Process:

AHCCCS creates a report for each CRS Contractor identifying the clients selected for review. The ADHS Data Validation Specialist will send the CRS Contractor the appropriate portion of the report and a computer disk that identifies the clients that are included in the data validation study. The CRS Contractor is responsible for identifying where the medical records are housed. The CRS Contractor must forward the list of where the medical records are kept to AHCCCS by the date specified. AHCCCS will prepare a letter to notify the CRS Contractor about the data validation process and its requirements. The CRS Contractor must locate the medical records for each of the clients requested and must forward the medical records to AHCCCS by the date specified.

Type of Errors Examined:

AHCCCS will review the medical records to determine what services the clients received. The services received will be compared to the encounters submitted to determine what types of errors, if any, exist. To comply with CMS requirements three types of errors are examined:

- Correctness-an error is assessed when the dates of service, procedure code and or diagnosis code in the encounter were incorrectly coded according to the medical documentation
- Timeliness- an error is assessed when the encounter is received by AHCCCS more than 240 days from the end of the month in which the service was rendered, or the effective date of the enrollment
- Omission- an error is assessed when provider documentation indicates that medical services were rendered, but an encounter was never received at AHCCCS

Preliminary Report Distribution, Review and Challenge

A preliminary report will be prepared and will be distributed to each CRS Contractor. This is the only opportunity that the CRS Contractor has to challenge the errors identified by AHCCCS. The CRS Contractor is responsible for identifying any errors that they want to challenge in the AHCCCS preliminary report. The CRS Contractor should review the preliminary error report and perform a comparison to data from the clientôs medical records and/or the CRS Contractorôs system. Each challenge must be supported by additional documentation. Types of additional documentation include, but are not limited to:

- PMMIS screen prints
- CRS screen prints
- Screen prints from the CRS Contractorôs internal system

All documentation required to support the challenge including the *Data Validation Challenge Form* (Attachment 1) must be submitted to OPS by the date specified. If the documentation does not support the challenge, the challenge will not be processed and forwarded to AHCCCS.

Methods for Challenging Errors:

The type of evidence that is required to successfully challenge an error is dependent on the type of error identified. This section describes some the techniques that may be useful in challenging data validation errors.

Remember: This is the <u>ONLY</u> opportunity for the CRS Contractor to challenge the errors identified by AHCCCS.

<u>Correctness Errors</u>-The CRS Contractor or the provider must:

- Submit documentation outside of the medical record supporting that the code or date on the encounter is the clinically correct code or date
- Show that the ICD9 diagnosis code in question did not require a 4^{th} or 5^{th} digit at the time the service was provided

<u>Timeliness Errors</u>-The CRS Contractor or the provider must:

- Document that the encounter could not be submitted in a timely fashion at AHCCCS because of system problems at AHCCCS during the relevant timeframe.
- Show that the encounter referenced is an adjustment and that the original encounter and the adjustment were both submitted in the correct time frame.

<u>Omission Errors</u>-The CRS Contractor must document that the encounter should never have been sent to AHCCCS because:

- The client was not eligible for Title XIX or XXI services
- The service was not covered by AHCCCS
- The provider was not eligible to bill for Title XIX or XXI services

Challenge Received:

The Data Validation Unit will review the preliminary report and the challenges submitted. The Data Validation Unit will create one unified challenge response containing all documented challenges noted by the CRS Contractor. This along with all the supporting documentation submitted will be forwarded to AHCCCS.

Final Report:

AHCCCS will review the challenges and documentation submitted. This review will result in a final report that is distributed to the appropriate CRS Contractor. Included with the final report is the sanction assessed by AHCCCS: the AHCCCS sanction calculation process is a complex multi-step process. Details regarding the AHCCCS sanction calculation process can be found in the *AHCCCS Encounter Data Validation Technical Document.* The ADHS process for passing the AHCCCS Sanction on to the CRS Contractor is as follows:

- ADHS takes the total sanction dollar amount and divides it by the total number of errors from AHCCCS, which results in a sanction amount per error.
- The sanction amount per error is then multiplied by the number of errors for each CRS Contractor resulting in a final sanction amount per CRS Contractor.

Note: This process is valid for both the ñAò and ñBò Study.

Collection of Sanction:

ADHS will withhold the final sanction amount from the capitation paid to the CRS Contractor each month.

Attachment 1

Arizona Department of Health Services
Division of Behavioral Health Services
Office of Program Support Services
2122 East Highland, Suite 100
Phoenix, Arizona 85016
Phone: (602) 381-8991
Fax: (602) 553-9023

DBHS Received Date

Data Validation Challenge

Preliminary Results are the Only Opportunity to Challenge the AHCCCS Data Validation Findings

CRS Site: ☐ Phoenix ☐ Flagstaff ☐ Tucson ☐ Yuma

CRS Representative: _____ **Phone:** _____

Client Information:

Client Name: _____

CIS Client ID: _____ AHCCCS Client ID: _____

Challenged Error:

☐ Omission ☐ Correctness ☐ Timeliness

AHCCCS Tracking #: _____

CIS ICN: _____ AHCCCS CRN: _____

Explanation of Challenge: _____

Please note: Without proper and legible documentation attached the challenge will not be forwarded to AHCCCS and the challenge will be considered unsubstantiated.

Required Documentation:

☐ CIS Screen Print ☐ PMMIS Screen Print ☐ RBHA Internal Screen Print ☐ Other Information as Needed to Support Claim

For ADHS Use Only: ADHS Reviewer: _____

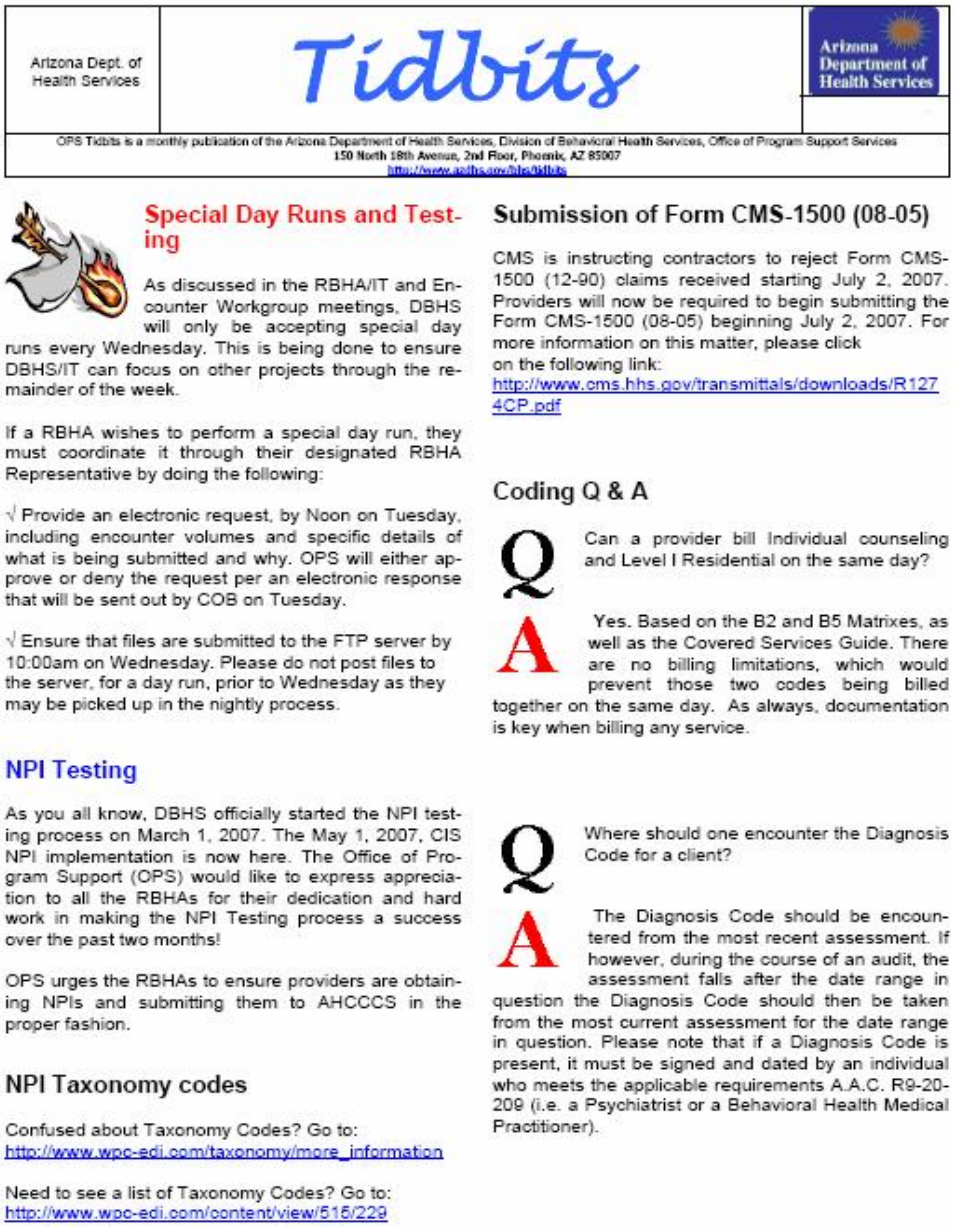
☐ Challenge Referred to AHCCCS Date: _____
☐ Challenge Determined to be BHS Responsibility
☐ Challenge Determined to be RBHA Responsibility

Comment: _____

Tidbits

Introduction

The Office of Program Support (OPS) produces a monthly newsletter called *Tidbits* that is posted on the ADHS/DBHS website at http://www.azdhs.gov/bhs/tidbits.htm . The purpose of the *Tidbits* is to keep the RBHAs and the CRS Contractors up to date with OPS changes, edit alerts and encounter processing information. The following is an example of the first page of a *Tidbits* issue:



Arizona Dept. of Health Services

Tidbits

Arizona Department of Health Services

OPS Tidbits is a monthly publication of the Arizona Department of Health Services, Division of Behavioral Health Services, Office of Program Support Services
150 North 18th Avenue, 2nd Floor, Phoenix, AZ 85007
http://www.azdhs.gov/bhs/tidbits

Special Day Runs and Testing

As discussed in the RBHA/IT and Encounter Workgroup meetings, DBHS will only be accepting special day runs every Wednesday. This is being done to ensure DBHS/IT can focus on other projects through the remainder of the week.

If a RBHA wishes to perform a special day run, they must coordinate it through their designated RBHA Representative by doing the following:

√ Provide an electronic request, by Noon on Tuesday, including encounter volumes and specific details of what is being submitted and why. OPS will either approve or deny the request per an electronic response that will be sent out by COB on Tuesday.

√ Ensure that files are submitted to the FTP server by 10:00am on Wednesday. Please do not post files to the server, for a day run, prior to Wednesday as they may be picked up in the nightly process.

NPI Testing

As you all know, DBHS officially started the NPI testing process on March 1, 2007. The May 1, 2007, CIS NPI implementation is now here. The Office of Program Support (OPS) would like to express appreciation to all the RBHAs for their dedication and hard work in making the NPI Testing process a success over the past two months!

OPS urges the RBHAs to ensure providers are obtaining NPIs and submitting them to AHCCCS in the proper fashion.

NPI Taxonomy codes

Confused about Taxonomy Codes? Go to:
http://www.wpc-edi.com/taxonomy/more_information

Need to see a list of Taxonomy Codes? Go to:
http://www.wpc-edi.com/content/view/515/229

Submission of Form CMS-1500 (08-05)

CMS is instructing contractors to reject Form CMS-1500 (12-90) claims received starting July 2, 2007. Providers will now be required to begin submitting the Form CMS-1500 (08-05) beginning July 2, 2007. For more information on this matter, please click on the following link:
http://www.cms.hhs.gov/transmittals/downloads/R1274CP.pdf

Coding Q & A

Q Can a provider bill Individual counseling and Level I Residential on the same day?

A Yes. Based on the B2 and B5 Matrixes, as well as the Covered Services Guide. There are no billing limitations, which would prevent those two codes being billed together on the same day. As always, documentation is key when billing any service.

Q Where should one encounter the Diagnosis Code for a client?

A The Diagnosis Code should be encountered from the most recent assessment. If however, during the course of an audit, the assessment falls after the date range in question the Diagnosis Code should then be taken from the most current assessment for the date range in question. Please note that if a Diagnosis Code is present, it must be signed and dated by an individual who meets the applicable requirements A.A.C. R9-20-209 (i.e. a Psychiatrist or a Behavioral Health Medical Practitioner).

System Service Requests

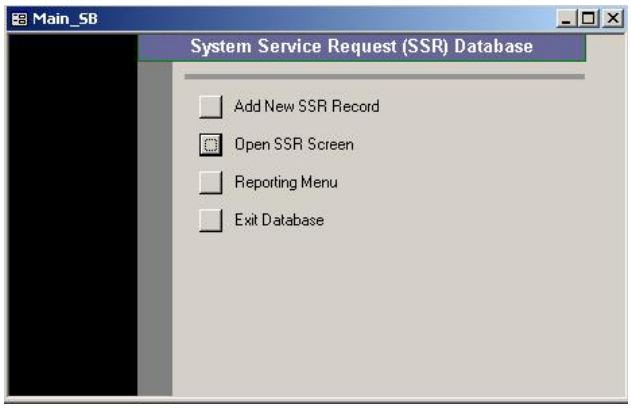
Introduction:

A System Service Request (SSR) is used internally by the Office of Program Support (OPS) to notify ADHS/IT of system changes/modifications needed in the Childrenôs Rehabilitative Services System (CRS). An SSR can also be used to request research of encounter issues or to request reports. For understanding, the process for the SSR is described below.

Create an SSR (ADHS process):

OPS staff can access the SSR database using the icon found on their desktop.

SSR Main Menu (for informative purposes)

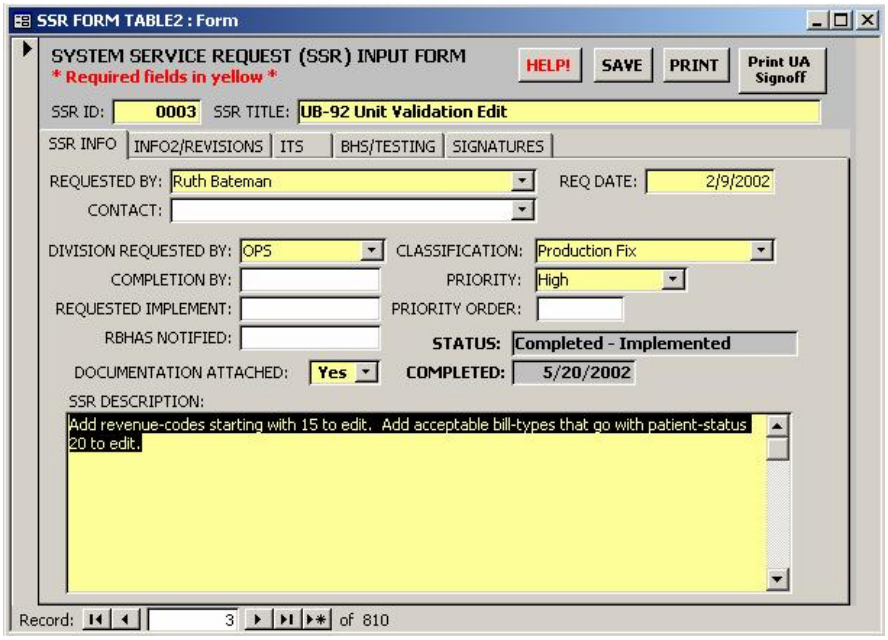


- **Add New SSR Record** ï Open SSR Input Screen to enter a new SSR
- **Open SSR Screen** ï Open SSR Input Screen to view all existing SSRs
- **Reporting Menu** ï Go to Report Menu
- **Exit Database** ï Exit system

Adding a New SSR Record

The following information is to be completed to add a new or change an existing SSR.

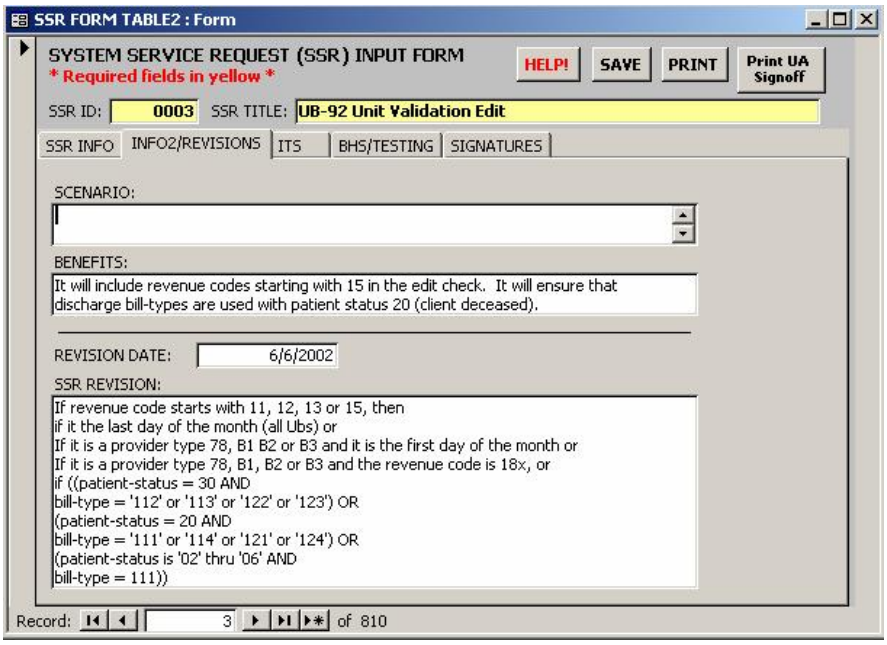
SSR INFO TAB



***Note*: Required fields are in yellow.**

- **SSR ID** ï Number automatically generated by SSR database
- **SSR TITLE** ï Brief description of request
- **REQUESTED BY** - Name of requester + **DATE** - Date request was created
- **CONTACT** ï Contact for questions regarding the request, if different from the Requester
- **DIVISION REQUESTED BY** - Requester's Division (pull down list)
- **COMPLETION BY** - If applicable, date the request needs to be completed
- **REQUESTED IMPLEMENTATION** - If applicable, requested date for implementation
- **RBHA/CRS NOTIFIED** - If applicable, date RBHA/CRS were notified of change
- **DOCUMENTATION ATTACHED** - Yes/No (default = "No")
- **CLASSIFICATION** - Type of request (pull down list, default = "Enhancement")
- **PRIORITY** - Requester's priority for request (pull down list, default = "Normal")
    - *Emergency*: Agency services immediately negatively affected
    - *High*: Important to Agency/Division - Complete after any emergencies
    - *Normal*: Change request will increase production - Complete as scheduled
- **PRIORITY ORDER** - Order in which requests will be prioritized and worked
- **STATUS** - Status of request (read-only, see ITS Tab to edit this field)
- **COMPLETED** - Date request was completed (read-only, see ITS Tab to edit this field)
- **SSR DESCRIPTION** - Detailed description of request

INFO2/REVISIONS TAB



- **SCENARIO** - A descriptive example of the problem or change
- **BENEFITS** - A description of any/all benefits of the request
- **REVISION DATE** - Date of revision (*Note: If there are multiple revisions, note the revision date for each one in the SSR Revision description field*).
- **SSR REVISION** - If applicable, a description of change to original request

After the SSR form has been completed it must be signed by the OPS Manager or the DBHS CFO.

Distribution of an SSR:

After an SSR is written and the originator has obtained all of the required signatures the SSR is distributed to the appropriate ADHS administrative Staff. The Administrative Staff will then:

- Make 2 copies of the SSR including any attached documentation
- Hand deliver the original SSR including all attached documentation to the ADHS IT department
- Deliver one copy including documentation to the SSR Originator
- The remaining copy will be used to create a testing folder which will be delivered to the Testing Unit.

It is the responsibility of the SSR Originator to follow-up on the progress/completion of the SSR request

Training Requirements

Introduction:

CRS Contractors are required to provide on-going training to their providers for submission of claim/encounter data.

Encounter Related Training:

The OPS Encounter Unit requires the CRS Contractor to provide evidence of on-going training that has been provided. The following evidence will be submitted at the monthly OPS/CRS workgroup meeting:

- Sign-in sheets for any training that took place in the previous month
- A brief description of the training provided

Data Validation Related Training:

The OPS Data Validation Unit requires the CRS Contractor to provide training to any provider with a data validation review error rate greater than 10%. The following evidence will be submitted at the monthly OPS/CRS workgroup meeting:

- Sign-in sheets for any training that took place in the previous quarter
- A brief description of the training provided

OPS Training Available

Any Site that would like to arrange training should contact their assigned OPS Representative.

CRS Administrative Review

Introduction:

Annually the ADHS/OPS conducts an Administrative review of each CRS Contractor. Monitoring and Scoring of the Administrative Review Standards is performed throughout the review year based on the following established policies/procedures.

Standard:

The Contractor has developed and maintained a system that meets claims/encounter data processing requirements defined by ADHS.

Scoring:

There are four elements that apply when evaluating the final score for meeting claims/encounter data processing requirements defined by ADHS:

- Meeting a 90% Acceptance Rate
- Meeting performance measured by the 210 Report
- Meeting the CRS Siteøs submission schedule and meeting performance measured by the Aged Pends Report.

Here is how each element is rated:

- **90% Acceptance**

  The total number of all encounters accepted / the total amount of all encounters submitted = passing/failing percentage

  - If the final percentage is 90% or above Score = 100%
  - If the final percentage is below 90% Score = 0%

- **210 Report**

  The total amount 210 PD / the total amount of encounters accepted = percentage

  Take the percentage and subtract by 100 to receive the final score

- **Submission Schedule**

  Each CRS Contractor should have 12 months worth of submission data to review for the Admin Review period (7/1/06 ï 6/30/07). If a CRS Contractor does not meet itøs predetermined submission schedule, for any one of the three form types, within a month,

it will be determined that they have not met the requirements of their submission schedule.

There are 12 possible points a CRS Site can obtain: Each month the CRS Site meets its submission schedule requirements; 1 point will be awarded. Each month the CRS Site fails to meet its submission schedule requirements; 0 points will be awarded.

The total points awarded / total months = percentage

(12/12) = 100%
(11/12) = 92%
(10/12) = 83%
(9/12) = 75%
(8/12) = 67%
(7/12) = 58%
(6/12) = 50%
(5/12) = 42%
(4/12) = 33%
(3/12) = 25%
(2/12) = 17%
(1/12) = 8%
(0/12) = 0%

- **Aged Pends**

The total number of pends > 120 days / the total number of pends = percentage

Take the percentage and subtract from 100 to receive the final percentage for this element

Each element should now have its own percentage. Add all acquired percentages together and then divide by 4 (the sum of all the elements). This will result in the final percentage, for this standard, which should be scored against the standard Admin Review scale:

90 ï 100% Full Compliance
75 ï 89% Substantial Compliance
50 ï 74% Partial Compliance
0 ï 49% Non-Compliance

Standard:

The CRS Contractor submits an accurate and timely override/deletion log from providers to the CRS Contractor and for encounters from the CRS Contractor to ADHS in accordance with OPS submission schedule.

There are two elements applied to the evaluation of the final scoring of the Administrative Review standard: timeliness and accuracy. The CRS Contractor must submit the override/deletion log by the OPS requested deadline and the file must be formatted according to specifications of the file layout. Each CRS Contractor should have submitted four override/deletion logs during the review period.

- The CRS Contractor submitted all four Override/Deletion logs timely and accurately ï 100% (Full Compliance)
- The CRS Contractor submitted three out of the four Override/Deletion logs timely and accurately ï 89% (Substantial Compliance)
- The CRS Contractor submitted two out of the four O/D logs timely and accurately ï 74% (Partial Compliance)
- The CRS Contractor submitted one out of the four O/D logs timely and accurately ï 49% (Non-Compliance)
- None of the O/D logs submitted by the CRS Contractor were timely and accurate ï 0% (Non-Compliance)

AHCCCS Operational and Financial Review

Annually, AHCCCS will conduct an Operational and Financial Review (OFR) of ADHS and CRS in order to determine if there are organization, management and administrative systems in place capable of fulfilling all contract requirements including those areas related to encounter submission and data validation.

System Access Requests

Introduction:

Some CRS employees will need access to the ADHS/CRS and/or AHCCCS/PMMIS claim systems to perform their job duties. The procedures to obtain a CRS and/or PMMIS IDs are as follows:

CRS

Two forms must be completed to request a CRS user ID. The employee requesting the login ID must complete and sign both forms. To obtain copies of the CRS forms, the CRS Site should contact the ADHS/DBHS Corporate Compliance Office.

- ADHS Computer User Registration Request Form (Attachment 1)
- ADHS User Affirmation Statement (Attachment 2)

The requestor should fax both signed forms to the ADHS/DBHS Corporate Compliance Office at fax number (602) 364-4736. The Corporate compliance Officer will review the forms to ensure they are complete and will forward the request to the ADHS/IT department. ADHS/IT will assign an appropriate login ID and password for the new user.

PMMIS

Two forms must be completed to request a PMMIS user ID. The employee requesting the login ID must complete and sign both forms. The CRS Contractor may obtain copies of the AHCCCS security forms at the following website:
http://www.ahcccs.state.az.us/Publications/Forms/PlansProviders/02-001F.doc

- AHCCCS User Access Request Form (Attachment 3)
- AHCCCS User Affirmation Statement (Attachment 4)

The CRS Site should fax both signed forms to the ADHS/DBHS Corporate Compliance Office at fax number (602) 364-4736. The Corporate compliance Officer will review the forms to ensure they are complete and will forward the request to AHCCCS. AHCCCS will assign an appropriate login ID and password for the new user.

Attachment 1

ADHS COMPUTER
USER REGISTRATION REQUEST FORM

MAIL TO: *Security Administration, ITS, 1740 W. Adams, Phoenix, 85007*
FAX #: *(602) 542-1235* **E-MAIL**: *SECURITY* **PHONE #**: *(602) 542-2810*

*** TO BE COMPLETED BY AUTHORIZED REQUESTOR ***

Please ☐ Add ☐ Remove ☐ Change *Request Date:* _____ *Effective Date:* _____

Last Name _____ First Name _____ MI _____ Working Title _____

(PRINT)

Office/Section _____ Physical Location _____ Phone _____

On the following systems/applications:

LANS = ☐ ACPTC ☐ HSP1 ☐ HSP2 ☐ BHS1 ☐ DHS1 ☐ EDC1
☐ EMS1 ☐ FHS1 ☐ FLG1 ☐ ITS1 ☐ LAB0 ☐ LAB1
☐ PHS1 ☐ TUC1 ☐ VRS1

NT Servers = ☐ BHSNT

OTHER = ☐ Internet

ALS = ☐ AMS ☐ CTS
BEMS = ☐ AMB ☐ EMP ☐ EMT
BHS = ☐ CIS ☐ OGA ☐ OHR Adhoc = (☐ CIS ☐ OGA ☐ OHR)
☐ IRS ☐ IRS
CFHS = ☐ CRS ☐ CATS ☐ CATS Claims ☐ Hlth Start ☐ Sensory
DIR = ☐ ODS
EDC = ☐ ASIIS ☐ BDR ☐ STD
FIN SVCS = ☐ AEDW ☐ EPR ☐ POTSY ☐ PPTS ☐ Supply
{DOA} ☐ USAS ☐ HRMS ☐ Fix asset ☐ Dataqry Acct: _____
PHS = ☐ Birth ☐ Death ☐ ATS
SLS = ☐ CLAS ☐ RLIMS ☐ ELBIS ☐ LITS ☐ CLIA
ITS = ☐ Unix ☐ AppWorx
ORACLE: ☐ asit ☐ tw ☐ cist ☐ crst ☐ natt ☐ vrst
☐ asip ☐ pw ☐ cisp ☐ crsp ☐ natp ☐ vrsp

Other Instructions: _____

Supervisor (PRINT): _____

Supervisor Signature: _____ *Phone:* _____

Data Owner Signature: _____ *Phone:* _____

Office: _____

*** TO BE COMPLETED BY THE ADHS SECURITY ADMINISTRATOR ***

Completed Date: ____/____/____

The following has been: ☐ Added ☐ Removed ☐ Changed

Login ID _____ Internet ID _____ LAN _____

Comments: _____

Signed: _____
Security Administrator

\\Common_MS\Forms\NewUser\User_reg - Edoc rev 09/03/2003

ADHS COMPUTER
USER REGISTRATION REQUEST FORM
INSTRUCTIONS

I. Fill out the top part of the form per the following instructions:

Add/Remove/Change	-	Check one of the boxes to indicate which action is needed. *{Required Field}*
Request Date	-	Enter the date this form is being filled out. (i.e. NOW) *{Required Field}*
Effective Date	-	If request is NOT to be done within 2 days, enter the date the requested action is needed. If blank, the request will be done within 2 days.
User Name	-	PRINT the complete name. (Last Name, First Name, and Middle Initial) User Name
Work. Title	-	Enter the working title of user. If the user is an outside consultant, write CONSULTANT in this space. *{Required Field}*
Office/Section	-	Enter the name of the office AND section where the user works. *{Required Field}*
Physical Location	-	User's work location. *{Required Field}*
Phone#	-	Enter the phone number of the user. *{Required Field}*
Appl/Systems	-	If this form is being filled out for a client user (i.e. non-ITS employee) check off only the particular application(s) (i.e. BDR, CLAS, USAS), into which the user needs to be added or removed. If this form is being filled out for ITS personnel who need general access to a computer system, also check those systems.
Other Instr	-	Write any other specific instructions the Security Administrator will need to know
Supvr. Name	-	PRINTED Supervisor Name. *{Required Field}*
Supvr. Signature	-	Supervisor's signature ONLY! Forms with any other signature will not be processed. *{Required Field}*
Phone#	-	Enter the phone number where the Supervisor can be reached if there are any questions. *{Required Field}*
Data Owner Sign.	-	Signature of the Person, or their designee, responsible for the data for which access is being requested
Phone#	-	Enter the phone number where the Data Owner can be reached if there are any questions
Office	-	Enter the name of the office where the Data Owner works.

II. Mail, hand deliver, E-MAIL, or FAX this request to the Security Administrator. (The mail address, E-MAIL name, and FAX # are at the top of the request form.) The request will be processed within 48 hours after being received.

(EXCEPTION: If a user needs to be <u>immediately</u> removed from the system, call the Security Administrator to facilitate special processing requirements.)

III. When the request has been processed, a copy of the completed form showing the login name and Internet ID, (if applicable), will be returned to the requestor by Inter-office Mail. Each new user added will also receive in a sealed envelope, their own unique USERID and INITIAL password.

Attachment 2

ARIZONA DEPARTMENT OF HEALTH SERVICES
USER AFFIRMATION STATEMENT

I have been made aware and understand that all personnel who have access to the Arizona Department of Health Services (DHS) data are bound by applicable laws, rules and DHS directives and are responsible for DHS data.
I agree to abide by all applicable laws, rules and DHS directives, and I pledge to refrain from any and all of the following:

1. Revealing DHS data to any person or persons outside or within DHS who have not been specifically authorized to receive such data.

2. Attempting or achieving access to DHS data not germane to my mandated job duties.

3. Entering/altering/erasing DHS data for direct or indirect personal gain or advantage.

4. Entering/altering/erasing DHS data maliciously or in retribution for real or imagined abuse, or for personal amusement.

5. Using DHS workstations, printers, and/or other equipment for other than work related purposes.

6. Using another person(s) personal logon ID and password.

7. Revealing my personal logon ID and password to another person.

8. Asking another person to reveal his/her personal DHS logon ID and password.

In relation to my responsibilities regarding the proprietary rights of the authors of computer software utilized by DHS, I recognize that:

1. DHS licenses the use of computer software from a variety of outside companies. DHS does not own this software or its related documentation and, unless authorized by the software developer, does not have the right to reproduce it.

2. When used on a local area network or on multiple machines, employees/contractors shall use the software in accordance with the license agreement.

3. Employees/contractors who know of any misuse of software or related documentation within the agency shall notify their manager/supervisor, or the department security administrator.

4. Employees/contractors making, acquiring or using unauthorized copies of computer software, or using personal non-DHS software are subject to punitive action in accordance with agency guidelines as appropriate to the circumstances.

5. According to U. S. Copyright Law, 17 USC Sections 101 and 506, illegal reproduction of software can be subject to criminal damages up to $250,000 and/or up to 5 years imprisonment.

6. In the event that an employee is sued or prosecuted for the illegal reproduction of software, he/she will not be represented by the Department of the Attorney General.

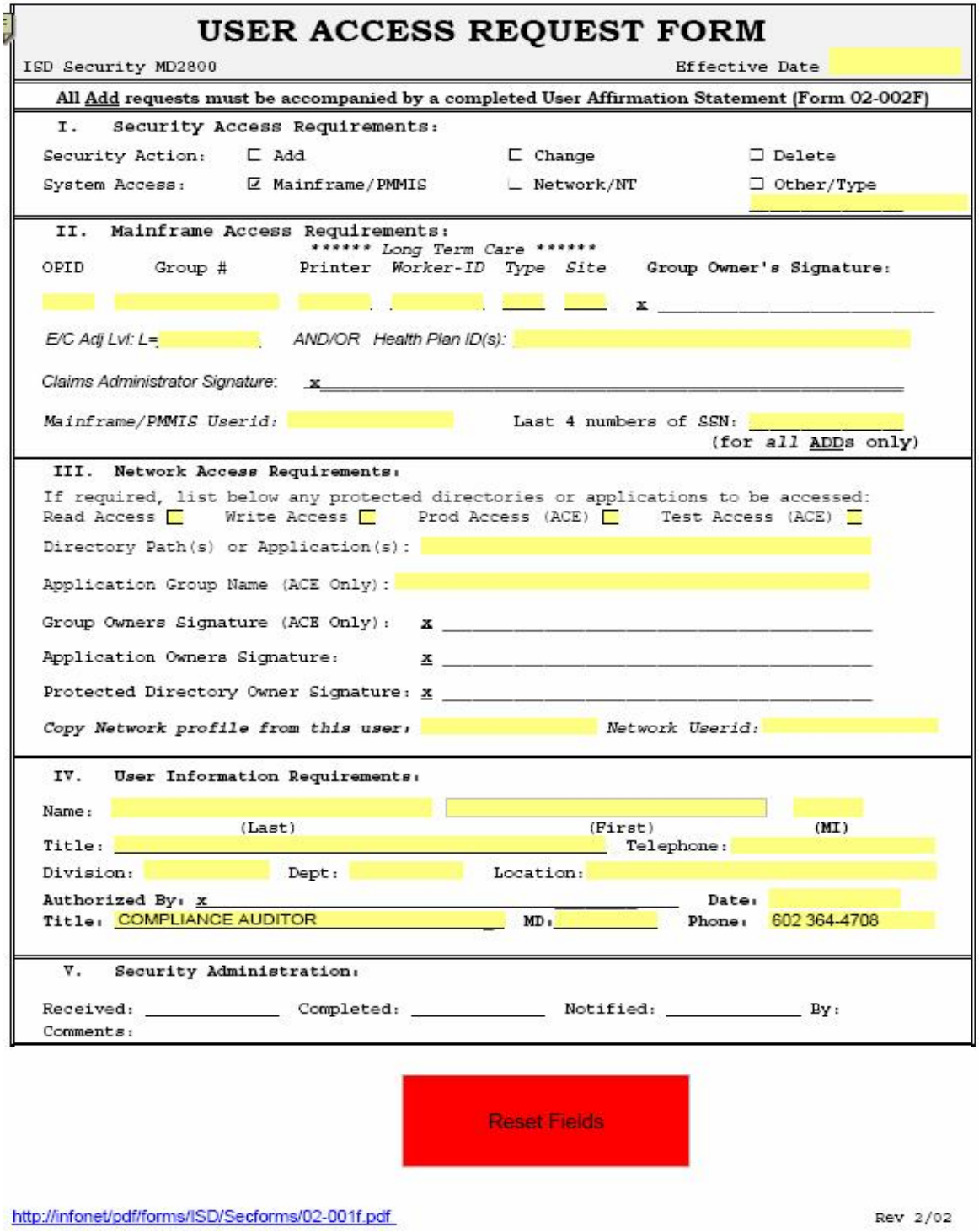
Appropriate action will be taken to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced. A breach of procedures occurring pursuant to this policy or misuse of department property including computer programs, equipment, and/or data, may result in disciplinary action including dismissal, and/or prosecution in accordance with any applicable provision of law including Arizona Revised Statutes, Section 13-2316.

My signature below confirms that I have read this form and accept responsibility for adhering to all applicable laws, rules, and DHS directives. Failure to sign this statement will mean that I will be denied access to DHS data, computer equipment, and software.

NAME *(Last, First, M.I.)* PRINT OR TYPE	SIGNATURE	PHONE	DATE
NAME OF SUPERVISOR *(Last, First, M.I.)*	SIGNATURE	PHONE	DATE

Routing: Original to Security Administrator; Copy 1-Originator

Attachment 3



USER ACCESS REQUEST FORM

ISD Security MD2800 Effective Date

All Add requests must be accompanied by a completed User Affirmation Statement (Form 02-002F)

I. Security Access Requirements:

Security Action: ☐ Add ☐ Change ☐ Delete

System Access: ☑ Mainframe/PMMIS ☐ Network/NT ☐ Other/Type

II. Mainframe Access Requirements:

****** Long Term Care ******

OPID Group # Printer Worker-ID Type Site Group Owner's Signature:

x

E/C Adj Lvl: L= AND/OR Health Plan ID(s):

Claims Administrator Signature: x

Mainframe/PMMIS Userid: Last 4 numbers of SSN:
(for all ADDs only)

III. Network Access Requirements:

If required, list below any protected directories or applications to be accessed:
Read Access ☐ Write Access ☐ Prod Access (ACE) ☐ Test Access (ACE) ☐

Directory Path(s) or Application(s):

Application Group Name (ACE Only):

Group Owners Signature (ACE Only): x

Application Owners Signature: x

Protected Directory Owner Signature: x

Copy Network profile from this user: Network Userid:

IV. User Information Requirements:

Name: (Last) (First) (MI)

Title: Telephone:

Division: Dept: Location:

Authorized By: x Date:

Title: COMPLIANCE AUDITOR MD: Phone: 602 364-4708

V. Security Administration:

Received: Completed: Notified: By:

Comments:

Reset Fields

http://infonet/pdf/forms/ISD/Secforms/02-001f.pdf Rev 2/02

Instructions for User Access Request Form

Date:	Enter the effective date in format mm/dd/yy.
	Section I, Security Access Requirements:
Security Action:	Check box(s) for action required. All three may be checked if multiple actions are to be made to multiple systems.
System Access:	Check box(s) for system to be accessed or changed. For Mainframe, complete sections II and IV. For Network, complete sections III and IV. For Other, indicate which region(s) (PRODCICS/AFIS, CICSPROD/HRMS, etc) or systems to modify/Add, and complete section IV and any other related sections. **Note:** Do not use this form for Oracle requests. Oracle forms can be found on the Infonet.
	Section II, Mainframe Access Requirements:
OPID:	Leave blank.
Group#:	See the PMMIS naming standards for correct Group Number values.
Long Term Care	
-Printer:	Leave blank unless defining a default PMMIS printer.
-Worker ID:	If required, enter either the valid case number provided by the supervisor, or the users first and last initial and the last four digits of the user SSN.
-Type:	If required, enter the correct two-digit Type code from the PMMIS Type Code Table.
-Site:	If required, enter the correct three-digit Site code from the PMMIS Site Code Table.
Authorized by Group Owner:	Signature of new user's PMMIS group owner.
E/C Adjudication Level:	If required, enter the valid two digit code (01-99)
Health Plan ID:	If required, enter the valid six digit Health Plan ID.
Claims Administrator Signature:	The Claims Administrator must sign here if Adjudication Code and/or Health Plan ID is assigned.
Mainframe Userid:	Will be entered by Security Administration if a new id is being created. If the logon is going to be Changed or Deleted, the requester should enter the user's logon id.
	Section III, Network Access Requirements:
Path(s) or Applications:	If yes, enter a valid path name that shows the location of the protected directory to be accessed, or enter the name of the application to be accessed. Indicate via the check boxes if the access should be read or write. (I.e. HomerDir\Share\Orange\Red\Blue\ or DADITS, ECS, ERVS, HRTS, HEIS, PARIS, PATS, etc.)
Protected Directory Owner Signature:	Signature of the Directory or Application Owner authorized to grant access to the protected Directory or Application. Call Security for information on Directory and Application Owners.
Copy network logon profile from this user:	Enter the name or ID of an existing user who has access to resources (directories, files, or applications) that this account should have access to. **Note:** This information is used to aid in the general definition of the new user. Access to protected directories or application will not be granted based on the field. The appropriate authorization signature is always required for access to protected resources.
Network/NT Userid:	Will be entered by Security Administration if a new id is being created. If the logon is going to be Changed or Deleted, the requester should enter the user's logon id.
	Section IV. User Information Requirements:
User Information:	Enter Name, Title, Division, Department and location of user. ***For Network signon ids, your middle initial is required.***
Authorized By:	Signature, date, title, mail drop, and extension of Security Representative or Supervisor.
	Section V. Security Administration:
	Security Administration section to be completed by the Security Administrator.

Attachment 4

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

USER AFFIRMATION STATEMENT

I have been made aware and understand that all personnel who have access to AHCCCS data are bound by applicable laws, rules and AHCCCS directives. I agree to abide by all applicable laws, rules and AHCCCS directives, and I pledge to:

1. Reveal AHCCCS data only to those persons, whether outside or within AHCCCS, who have been specifically authorized to receive such data.
2. Only access AHCCCS data germane to my assigned job duties.
3. Never enter/alter/erase AHCCCS data for direct or indirect personal gain or advantage.
4. Never enter/alter/erase AHCCCS data maliciously or in retribution for real or imagined abuse, or for personal amusement.
5. Use AHCCCS computer programs, e-mail, terminals, printers, and/or other equipment only for work-related purposes.
6. Never use another employee's AHCCCS Logon ID and password or ask another employee to reveal his/her personal AHCCCS Logon ID and password.
7. Never reveal my AHCCCS Logon ID and password except to the Assistant Director of my division, the Agency Director or Deputy Director, upon request.

In addition, I recognize that:

1. AHCCCS licenses the use of computer software from a variety of outside companies. Neither AHCCCS nor its employees own this software or its related documentation and, unless authorized by the software developer, do not have the right to reproduce or alter the software or the documentation.
2. AHCCCS employees should not acquire or use unauthorized copies of computer software.
3. When used on a local area network or on multiple machines, AHCCCS employees shall use the software in accordance with the license agreement.
4. AHCCCS employees who know of any misuse of software or related documentation within the agency shall promptly notify their manager/supervisor or Assistant Director.
5. According to U.S. Copyright Law, 17 USC Sections 101 and 506, illegal reproduction of software can be subject to criminal damages up to $250,000 and/or up to five (5) years imprisonment.
6. The Arizona Attorney General's Office will not represent and the agency will not provide legal representation to an employee who is sued or prosecuted for the illegal reproduction of software.

Appropriate action will be taken to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced. A breach of procedure occurring pursuant to this policy or misuse of AHCCCS property including computer programs, e-mail, equipment and/or data may result in disciplinary action up to and including dismissal, and/or prosecution in accordance with any applicable provision of law, including Arizona Revised Statutes, Section 13-2316.

My signature below confirms that I have read this form and understand it. I accept responsibility for adhering to all applicable laws, rules, and AHCCCS directives. Failure to sign this statement will mean that I will be denied access to AHCCCS data, computer equipment, and software.

NAME OF EMPLOYEE (*Last, First, M.I.*) Print or Type	SIGNATURE	MAIL DROP	DATE

Routing: Pink (original) - Employee Personnel File; Canary - ISD; Green - Employee.

S:\HRD\HRP\FORMS\USERAFF.DOC
Rev. 3-26-97

Reset Form

02-002F

Operations and Procedures Manual Updates and Revisions

The OPS Operations and Procedures Manual will be reviewed and updated as needed. The OPS Manger is responsible for maintaining this manual and should coordinate with all functional areas of ADHS and CRS when there are proposed changes. All functional areas of ADHS and CRS should coordinate with the OPS Manager regarding any changes in their policies, procedures, contracts or reference documents that may affect this manual.

Check Register Review

Introduction:

OPS requires all CRS Sites to submit check registers for all Fee-For-Service (FFS) paid claims on a quarterly basis to ensure a CRS Site is submitting timely and accurate encounter data. Check register reviews are scored as part of each Siteôs yearly Administrative Review.

Check Register Request:

On a quarterly basis, OPS Representatives send a request to each Site via email stating that the Siteôs check register from the previously ended quarter is due to ADHS/OPS (Attachment 1). The Site is given 10 business days from the date of the email to submit their check register.

Timeframes to be followed:

- The 1st business day of the month the OPS Representative will send an email to each CRS Site requesting the check register for the appropriate fiscal year quarter.
- The CRS Site will be given 10 business days to return the check register to their respective OPS Representative.
- Within 5 business days, the OPS Representative will submit a request to the CRS Site for copies of the checks, either the first paid claim on checks where a single claim was paid or the third paid claim on checks where multiple claims were paid.
- The CRS Site will be given 10 business days to submit the requested information to the appropriate OPS Representative.
- The OPS Representative will review the submitted information and provide the CRS Site with the outcome within 10 business days from the day the second request was received. CRS Sites will be sent a preliminary letter summarizing the findings along with a spreadsheet of the claims reviewed.

Check Register Received:

Once the OPS Representative receives a check register, the review will begin. Within 5 business days of receiving the check register, the OPS Representative will submit a second request (Attachment 2) and a Check Register Claim Request spreadsheet (attachment 3), via email, to the CRS Site for the FFS claims and copies of either the first paid claim on checks where a single claim was paid or the third paid claim on checks where multiple claims were paid. The CRS Site will be given 10 business days to submit the requested information to the OPS Representative. Upon receipt of the FFS claims request, the OPS Representative shall begin the sample selection process.

Sample Selection Process:

The OPS Representatives have two weeks to research the submitted information by randomly selecting 20% (not to exceed 150) of the encounters to review for correctness, timeliness or omission errors. If the check register contains fewer than 30 check numbers associated with Fee-For-Service paid claims, the entire check register will be reviewed.

How to Determine Encounter Errors:

Correctness: The service dates, procedure code, modifier, units, dollar amounts, and diagnosis codes are compared against a copy of the providersô claim, which is supplied to the OPS Representative by the CRS Site. If what the CRS Site adjudicated in their system does not match what the provider billed, a correctness error will result. If both a correctness and timeliness error are found on a single encounter, only the correctness error is calculated into the score. CRS Sites must adjust all correctness errors found and resubmit to ADHS within 10 business days from the date the preliminary letter was sent to the Sites.

Timeliness: An encounter must reach the CIS system at ADHS within 210 calendar days from the end date of service billed, or the encounter is considered untimely, and will result in a timeliness error. Additionally, adjustments of an encounter must be completed and accepted into CIS within 210 calendar days from the end date of service billed to be considered timely.

Omissions: OPS representatives are to work closely with the CRS Sites before omission errors are cited because CRS Sites have 210 calendar days from the end date of service to submit a clean claim to ADHS. The following are the steps an OPS Representative should follow before calling an omission error:

- Contact the CRS Siteôs Claims department and request documentation of claim status.
- Determine the date the claim was adjudicated in the CRS Siteôs system. The CRS Site must provide a screen print to document that the claim is in their system.
- If the claim has been cleanly adjudicated in the CRS Siteôs system with a process date prior to the date the check was written, the encounter is not considered an omission. The CRS Site will be required to submit a screen print from their claim system demonstrating the above information.
- If a claim is older than 210 calendar days from the end date of service and has not yet been submitted to ADHS, the encounter is an omission.

If any omissions are identified during the course of the review, the score will automatically default to a 0% rating.

Scoring the Check Register Review:

Within two weeks of receiving the FFS claims from the CRS Site, ADHS/OPS will compute each CRS Siteôs score by dividing the number of correct claims by the total number of claims reviewed. If any omissions are identified during the course of the review, the score will automatically default to a 0% rating. Score and compliance rating are then based on the following table. Corrective action will be requested as applicable.

Score	Rating
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

Preliminary Findings:

Within 10 business days from receipt of the claims, the OPS Representative will prepare and issue the preliminary findings (Attachment 4) including a spreadsheet of the claims reviewed (Attachment 5).

Challenges:

The CRS Sites have 10 business days to challenge the preliminary findings of a Check Register Review from the date of the preliminary letter

Final Score:

OPS Representatives must take into consideration any challenges before calculating the final score of the quarterly Check Register Review. The final score must be determined within 5 business days from the due date provided in the preliminary letter, and a final letter sent to the CRS Site stating the number of errors and the final score (Attachment 6).

Correction of Errors:

It is the expectation of the Office of Program Support that all correctness and omission errors will be corrected and/or submitted within 30 days from the date of the final letter. The OPS Representative will monitor CRS to ensure corrections are made in a timely manner. If corrections have not occurred the issue will be discussed with the CRS Site at the Workgroup meetings.

Admin Review Scoring:

The Check Register Review process is monitored as part of the CRS Siteôs yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review section of this manual.

Check Register Request Template Attachment 1

[Date of Request]

In accordance with the following schedule the Office of Program Support is beginning the [1st, 2nd, etc.] Quarter, fiscal year [2007], Check Register Review process. Please submit Fee-For-Service (FFS) check registers for the months of [i.e. October, November, and December] [Year], to the attention of [OPS Representative] by [10 Business Dayôs from Date of Request].

Quarterly Review Month	**Check Register Requested**
October 2006	1st quarter, fiscal year 2007
January 2007	2nd quarter, fiscal year 2007
April 2007	3rd quarter, fiscal year 2007
July 2007	4th quarter, fiscal year 2007

If you have any questions please do not hesitate to contact me.

[OPS Representative]
[Title]
[Phone]
[Fax]
[Email Address]

FFS Claims Request Template

Attachment 2

Subject: [FY07 ï 2nd Quarter], FFS Claims Request

Dear [Recipient],

Thank you for your response to the previous check register request. ADHS/OPS has reviewed the check register for the quarter ending [December 2006], and has randomly selected a 20% sample of checks associated with the Fee-For Service paid claims. The next step in the review process will be to examine the paid FFS claims. Please submit the third paid claim from each of the checks listed on the attached spreadsheet. If the identified check contains less than three paid claims, please provide a copy of the first paid claim. This information should be sent to the attention of [RHBA Representative] by [End of Month].

Please feel free to contact me should you have any questions or require any additional information.

Thank you,
[RBHA Representative]
[Title]
[Phone]
[Fax]
[Email Address]

Attachment 3

Check Register Claim Request

CRS Site:

Quarter Reviewing: Register Month Requested:

Please provide ADHS with the third paid claim from each of the listed checks. If the identified check contains less then three paid claims, please provide a copy of the first paid claim.

Check Number	Check Date	Vendor	Check Amount	Invoice Number	Invoice Date	Invoice Amount	Payment Amount

Page Of

Attachment 4

Check Register Review Preliminary Letter Template

[Date]

[Recipient]
[Site]
[Street Address]
[City, State Zip]

Dear [Dr./Mr./Ms.] [Recipient],

The Arizona Department of Health Services/Office of Program Support (ADHS/OPS) has concluded its preliminary findings of the [*first, second, etc.*] quarter, fiscal year [2007] Fee-For-Service (FFS) Check Register Review. The claims in the attached Check Register Review Summary have been researched to determine if omission, correctness or timeliness errors exist. If a claim has both a correctness and timeliness error, only the correctness error has been calculated in the findings. If any omissions were identified during the course of the review, the score was automatically defaulted to a 0% rating.

Type of Error	Encounters Reviewed	Number of Errors	Compliance Rate
Correctness			%
Omission			%
Timeliness			%
Total			%

Score Rating	
90-100%	**Full Compliance**
75-89%	**Substantial Compliance**
50-74%	**Partial Compliance**
0-49%	**Non Compliance**

The preliminary score of this review is [ ]%, which represents [*Score Rating*] Compliance. Any challenges must be presented to OPS within 10 business days from the date of this letter. If you have any questions regarding your score or the Check Register Review process, please do not hesitate to contact me at (602) [Phone Number].

Sincerely,

[Name]
Encounters Unit Supervisor

Enclosures

c: [Name, CFO/CEO], CRS
[Name] OPS Manager, ADHS
[Name] Office Chief, CRS
[Name] Division Chief Compliance, CRS
[Name] CFO, CRS
[Name] Encounter Manager, ADHS

Check Register Review Encounter Summary Template

Attachment 5

ADHS/OPS Check Register Review Summary

		Claim						CRS							PMMIS								Error Found						
																									Correctness				
Client ID	Provider ID	DOS	Service Code	Units	Billed Amount	Diagnosis code	Date Paid	ICN	DOS	Service Code	Units	Billed Amount	Diagnosis Code	CIS Add Date	CRN	DOS	Service Code	Units	Billed Amount	Diagnosis Code	PMMIS Add Date	Encounters Status	Omission	Timeliness	Service Code	Diagnosis Code	Units	Billed Amount	Comments

Total Clean Claims Divided By the Total Claims = Score
Clean Claims _____ Total Claims _____ Score _____

Page 1 of 1

Check Register Review Final Letter Template Attachment 6

[Date]

[Recipient]
[Site]
[Street Address]
[City, State Zip]

Dear [Dr./Mr./Ms.] [Recipient],

The Arizona Department of Health Services/Office of Program Support (AHDS/OPS) has completed the [*first, second, etc.*] quarter, fiscal year 2007 Fee-For-Service (FFS) Check Register Review. The claims in the Check Register Review Summary were reviewed to determine if omission, correctness or timeliness errors exist. If a claim has both a correctness and timeliness error, only the correctness error has been calculated in the findings. If any omissions are identified during the course of the review, the score will automatically default to a 0% rating.

Type of Error	Encounters Reviewed	Number of Errors	Compliance Rate
Correctness			%
Omission			%
Timeliness			%
Total			%

Score Rating	
90-100%	**Full Compliance**
75-89%	**Substantial Compliance**
50-74%	**Partial Compliance**
0-49%	**Non Compliance**

The final score of this review is [ ]%, which represents [*Score Rating*] Compliance. It is the expectation of OPS that all correctness errors will be corrected and submitted within 30 days from the date of this letter. If you have any questions regarding your score or the Check Register Review process, please do not hesitate to contact me at (602) [phone number].

Sincerely,

[Name]
Encounters Unit Supervisor

Enclosures

c: [Name, CFO/CEO], CRS
[Name] OPS Manager, ADHS
[Name] Office Chief, CRS
[Name] Division Chief Compliance, CRS
[Name] CFO, CRS
[Name] Encounter Manager, ADHS

Coordination of Benefits

Introduction:

CRS Regional Contractors are required to take reasonable measures to determine the legal liability of third parties who are liable to pay for covered services.

Policy:

CRS Regional Contractors shall cost-avoid a claim if it establishes the probable existence of a third party or has information that establishes that third party liability exists. However, if the probable existence of third party liability cannot be established or third party liability benefits are not available to pay the claim at the time the claim is filed, the CRS Regional Contractor must process the claim. If a CRS Regional Contractor knows that the third party insurer will not pay the claim for a covered services due to untimely claim filing or as the result of the underlying insurance coverage (e.g., the service is not a covered benefit), the CRS Regional Contractor shall not deny the service, deny payment of the claim based on third party liability, or require a written denial letter if the service is medically necessary. The CRS Regional Contractor is required to reimburse providers for previously recouped monies if the provider was subsequently denied payment by the primary insurer based on untimely filing limits or lack of prior authorization and the member failed to disclose additional insurance coverage other than AHCCCS.

Provider Registration

Introduction:

All providers are required to register with the AHCCCS Administration and obtain an AHCCCS provider identification number.

Providers are required to:

- Complete an application
- Sign a provider agreement
- Sign all applicable forms, and
- Submit documentation of their applicable licenses and/or certificates

Information may be obtained by calling the AHCCCS Provider Registration Unit at:

Phoenix area: (602) 417-7670 (Option 5)
In-state: 1-800-794-6862 (Option 5)
Out of state: 1-800-523-0231, Ext. 77670

AHCCCS Provider Registration materials are available on the AHCCCS Web site at www.ahcccs.state.az.us .

National Provider Identifier (NPI)

Effective January 23, 2004, the final rule regarding the National Provider Identifier (NPI) was published. CMS started assigning NPI numbers to providers last May, and beginning in May 2007 NPIs are required. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Health Care Providers *must* communicate their National Provider Identifier's [NPIs] directly to the AHCCCS Administration,

The following outlines 3 Options for getting the required NPI information to the AHCCCS Administration.

Option 1: An electronic mailbox has been established for providers to forward a copy of their NPI notification via email. This email address can only accept copies of the statement emailed to the provider from the NPI enumerator. Please note that the Provider AHCCCS ID number also needs to be included in the email for identification purposes. This email address is NationalProviderID@azahcccs.gov.

Option 2: Providers may submit a copy of the NPI notification received from the NPI enumerator, either via mail or fax. Again, the providerôs name and AHCCCS ID number need to be included on the document. The information should be mailed or faxed to:

AHCCCS
Provider Registration Unit
P.O. Box 25520
Phoenix, AZ 85002
Mail Drop 8100
FAX: (602) 256-1474

Option 3: NPI numbers will also be accepted via written notification. Notification must include the providerôs name, AHCCCS ID number, NPI number and signature of the provider or an authorized signor.